SUPPLEMENT
The Association

THE CONJOINT MEETING OF THE AMERICAN MEDICAL ASSOCIATION AND CANADIAN MEDICAL ASSOCIATION, ATLANTIC CITY

June 10th to 14th, 1935

DURING the week of June 10th, approximately 8,500 doctors, members of either the Canadian or American Medical Association, along with 5,200 wives of doctors, students, and nurses, assembled in Atlantic City to celebrate the eighty-sixth annual session of the American Medical Association and the sixty-sixth annual convention of the Canadian Medical Association. This is the first occasion on which these two Associations have met together and the first time the Canadian Medical Association has met outside of Canada.

The business sessions of the House of Delegates of the American Medical Association were held at the Ambassador Hotel, while the Council of the Canadian Medical Association met at Haddon Hall.

The scientific sessions were held at the Convention Auditorium, where the scientific and commercial exhibits were also housed.

On Monday, June 10th, representatives of the House of Delegates of the American Medical Association were guests of the Canadian Medical Association at luncheon at Haddon Hall. At this luncheon, our retiring President, Dr. J. S. McEachern, gave his valedictory address which was followed by the installation of the new President, Dr. J. C. Meakins, of Montreal.

The first open general meeting was held on Tuesday evening. Addresses were given by Dr. Jas. S. McLester, President, American Medical Association, on "Nutrition and the Future of Man"; and by Dr. J. C. Meakins, President, Canadian Medical Association, on "The Breath of Life".

Meeting of Council

The first session of Council was held in Haddon Hall Hotel on Monday morning, June 10th, commencing at 9.30 o'clock. The Chairman, Dr. Geo. S. Young, welcomed the members in attendance.

The following delegates, 63 in number, answered to the roll call:—

Drs. Geo. S. Young (*Chairman*), Toronto; G. Harvey Agnew, Toronto; J. Fenton Argue, Ottawa; A. T. Bazin, Montreal; J. E. Bloomer, Moose Jaw; Wesley Bourne, Montreal; J. F. Burgess, Montreal; E. O. Caza, Valleyfield; L. L. Charpentier, Drummondville; H. H. Christie, Esterhazy; G. H. Clement, Vancouver; D. E. H. Cleveland, Vancouver; W. K. Colbeck, Welland; W. H. Delaney, Quebec; C. E. A. DeWitt, Wolfville; L. C. Edmonds, Toronto; A. Grant Fleming, Montreal; A. E. Forbes, Kentville; W. E. Gallie, Toronto; Léon Gérin-Lajoie, Montreal; A. L. Gerow, Fredericton; J. C. Gillie, Fort William; Duncan Graham, Toronto; Roscoe R. Graham, Toronto; H. G. Grant, Halifax; W. Everett Gray, Milltown; R. I. Harris, Toronto; J. J. Heagerty, Ottawa; C. P. Howard, Montreal; F. W. Jackson, Winnipeg; G. R. Johnson, Calgary; A. S. Kirkland, Saint John; W. J. Knox, Kelowna; W. S. Lyman, Ottawa; C. F. Martin, Montreal; J. C. Meakins, Montreal; A. H. Meneely, Coronation; H. H. Milburn, Vancouver; Ross Millar, Ottawa; W. T. B. Mitchell, Montreal; W. L. Muir, Halifax; J. K. Mulloy, Cardston; G. W. Mylks, Kingston; H. E. MacDermot, Montreal; J. S. McEachern, Calgary; K. A. MacKenzie, Halifax; F. C. Neal, Peterborough; A. G. Nicholls, Montreal; John Oille, Toronto; F. S. Patch, Montreal; E. L. Pope, Edmonton; A. Primrose, Toronto; J. W. Richardson, Calgary; Hermann Robertson, Victoria; F. W. Routley, Toronto; T. C. Routley, Toronto; Sir Francis Shipway, London, Eng. (visitor); Miss Elizabeth Smellie, Ottawa; Drs. Jas. Stevenson, Quebec; F. F. Tisdall, Toronto; R. E. Valin, Ottawa; C. J. Veniot, Bathurst; A. MacG. Young, Saskatoon.

Messages of regret at inability to be present and greetings to the Association assembled in Atlantic City were received from Dr. J. G. FitzGerald, a member of the Executive Committee, at present in Dublin; Dr. J. W. McKenzie, Charlottetown; Dr. H. H. Murphy, Victoria; Dr. G. A. B. Addy, Saint John; and Dr. Ward Woolner, Ayr, Ont.

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REPORT OF THE COMMITTEE ON ARCHIVES

Mr. Chairman and Members of Council:—

Your Committee on Archives reports with regret the loss of the following members, by death, during the past year:—

Abramson, H. L., Saint John, N.B.
Anderson, George Church, Montreal, Que.
Bowie, T. Innes, Streetsville, Ont.
Boyd, Geoffrey, Toronto, Ont.
Butters, Thomas Lowell, Vancouver, B.C.
Byers, H. P., Melita, Man.
Campbell, Spurgeon, Winnipeg, Man.
Carr, Leeming, Hamilton, Ont.
Chandler, A. B., Montreal, Que.
Cochran, Francis James Albro, Toronto, Ont.
Craig, Robert Henry, Montreal, Que.
Crosby, Robert, Vancouver, B.C.
Dales, John Robert, Dunbarton, Ont.
Elliott, William, Wolseley, Sask.
Esdale, William Rupert, Ottawa, Ont.
Faucher, Pierre Vincent, Quebec, Que.
Fleming, George W., Petitcodiac, N.B.
Ferguson, John Irwin, London, Ont.
Frain, Charles Elias, Haliburton, Ont.
Fuller, Aubrey Taylor, Vancouver, B.C.
Fulton, Silas Arthur, Truro, N.S.
Glassco, Gerald Stinson, Hamilton, Ont.
Girvin, Alfred Weller, Calgary, Alta.
Goodchild, John Fleming, Toronto, Ont.
Goodwill, Victor L., Charlottetown, P.E.I.
Groves, Abraham, Fergus, Ont.
Hallett, Edmund Oliver, Weymouth, N.S.
Hamilton, Thomas Glendenning, Winnipeg, Man.
Harding, Victor John, Toronto, Ont.
Harwood, Louis de Lotbinière, Montreal, Que.
Hiebert, Gerhard, Winnipeg, Man.
Howitt, Henry, Guelph, Ont.
Kaiser, Philip Reide, Tottenham, Ont.
King, Charles A., Sussex, N.B.
Lauchland, Lyman Craig, Dundas, Ont.
Lehmann, Julius Edward, Winnipeg, Man.
Little, Herbert Melville, Montreal, Que.
Marlow, Frederick Charles, Toronto, Ont.
Meighen, William Arthur, Perth, Ont.
Montague, Albert William, Victoria, B.C.
Morgan, Arthur David, Alberni, B.C.
Mulligan, Frederick William, Petrolia, Ont.
Murray, Suther Corbet, Albert, N.B.
MacArthur, John Alexander, Winnipeg, Man.
McCalla, Arthur Irvine, Calgary, Alta.
McCracken, William Alexander, Montreal, Que.
McEdwards, Duncan, Hamilton, Ont.
McIntosh, Lorne DeCorsia, Hartland, N.B.
Mackay, Donald MacGregor, Vancouver, B.C.
MacKay, Gordon Russell, Hagersville, Ont.
Mackay, Hugh, Winnipeg, Man.
MacKay, Murdoch Angus, Tisdale, Sask.
McKelvey, Alexander Dunbar, Toronto, Ont.
Maclennan, Duncan Neil, Toronto, Ont.
MacLennan, Mary Muriel Currie, London, Ont.
McPhedran, Alexander (Life Member), Toronto, Ont.
Oaks, Anthony, Preston, Ont.
Powell, Newton Albert (Life Member), Toronto, Ont.
Powell, Robert Wynyard (Life Member), Ottawa,Ont.
Procter, Arthur Percival, Vancouver, B.C.
Purdy, W. T., Amherst, N.S.
Rankin, James Palmer, Stratford, Ont.
Rockwell, William, River Hebert, N.S.
Smith, Joseph Rymal, Grimsby, Ont.
Spankie, William, Wolfe Island, Ont.
Stephanson, Stephan, The Pas, Man.
Stewart, John (Life Member), Halifax, N.S.
Stockwell, Henry Perkins, Stanstead, Que.
Taylor, D. A., Lethbridge, Alta.
Tessier, Romuald, Laval-sur-le-Lac, Que.
Turnbull, James L., Vancouver, B.C.
Vanderlip, Frank, Brampton, Ont.
Walters, Eugene, Winnipeg, Man.
Wardlaw, James Syme, Galt, Ont.
Webster, Alexander Vernon, Vancouver, B.C.
Webster, William, Winnipeg, Man.
West, C. H., Mayne Island, B.C.
Wishart, David James Gibb, Toronto, Ont.
Yorston, Frederic Pottinger, Montreal, Que.

Dr. H. E. MacDermot, during the past year, has completed the history of the Association, and it is now being prepared for publication. The history consists of a review of the growth of the Association from its earliest days, preceded by a short sketch of medical Canadian life before the year 1867. There are also biographical notes on some outstanding Canadian men of the Association.

Your Committee has continued to collect material for the Archives, and I would again appeal to members of the Association to forward to the undersigned any documents or items of historical interest, photographs, etc., for filing with the Archives at the McGill Medical Library.

All of which is respectfully submitted.

C. F. WYLDE,
Chairman.

Approved.

REPORT OF THE EXECUTIVE COMMITTEE

This report was considered clause by clause.

Mr. Chairman and Members of Council:—

Your Executive Committee has held three meetings since its election last June; at Calgary, June 21st, 1934; Ottawa, October 30th, 1934; Toronto, April 6th, 1935; and a fourth meeting will be held prior to the meeting of Council in Atlantic City. At its first meeting, the Committee elected Dr. Geo. S. Young to be its Chairman. In the report which follows, reference is made to the more important items which engaged the attention of your executive Committee during the year.

JOINT MEETING WITH THE AMERICAN MEDICAL ASSOCIATION

While our Annual Meeting was in progress in Calgary, the following telegram was received:—

> "House of Delegates of the American Medical Association unanimously and enthusiastically approve proposal of Board of Trustees to extend invitation to Canadian Medical Association to join with American Medical Association in scientific session in 1935. Invitation extended to your Association with utmost possible cordiality and enthusiasm. Sincerest good wishes for success for your Calgary Meeting."
>
> Olin West, Secretary,
> American Medical Association.

This communication was presented to Council and the General Secretary instructed to send the following telegraphic reply:—

> "Canadian Medical Association in annual session assembled in Calgary acknowledges with deepest appreciation invitation from American Medical Association to meet with you in Atlantic City in June, 1935. Instructed to advise that invitation has been unanimously and enthusiastically accepted; and we anticipate with keenest interest and pleasure the privilege of meeting with your honourable Association."

This invitation having been received and accepted, it became necessary for your Executive Committee at once to give attention to the necessary preparations to be undertaken by our Association in respect to the joint meeting. To that end, Committees were appointed to deal with program, scientific exhibits and general detail. On November 10th, the President-Elect, Dr. J. C. Meakins, of Montreal, the Chairman of Council, Dr. Geo. S. Young, of Toronto, the Chairman of the Central Program Committee, Dr. A. Primrose, of Toronto, and the General Secretary, attended a meeting in Chicago, to confer with the officers and members of Committees of the American Medical Association. At this meeting, plans for the joint session were discussed and consummated. Thirty-two Canadians are members of the Committees in charge of the program, while close upon one hundred of our Canadian colleagues are taking part in the program. Naturally, the attention of both Associations had to be directed to a great many details, and throughout the year's preparation, there has existed between the two Associations the closest co-operation and harmony. That Council will be meeting to conduct its business outside the borders of our own country demonstrates more clearly than words could do the bond of friendship that exists between the two neighbouring countries, not only medically but in all other respects.

JOINT MEETING IN CANADA

The suggestion was made and unanimously approved that an invitation be extended to the American Medical Association to meet in Canada in the near future, and that an effort be made to get the British Medical Association to meet in Canada at the same time. It was the general opinion of the members of Council that this joint meeting should take place, if possible, not later than the year 1940.

GREETINGS FROM THE PRIME MINISTER OF CANADA

The following greeting from the Right Honourable R. B. Bennett, Prime Minister of Canada, was read at the Monday luncheon, at which representatives of the House of Delegates of the American Medical Association were present; and also at the General Meeting on Tuesday evening:—

> "The meeting in Atlantic City, New Jersey, of the Medical Associations of the United States and Canada is a unique event in the medical history of this continent. In no single field of human endeavour has the imagination been more completely captivated than by the work of medical science of our generation in its fight for humanity against disease and death. The contribution alike of the United States and Canada is evidenced by names of men whose reputations extend to all parts of the world. I am sure that your meeting will be both pleasant and profitable. Please convey to the members of both Associations my cordial greetings and sincere good wishes for their success in their fine efforts for humanity."

PRESENTATION OF A GAVEL TO THE AMERICAN MEDICAL ASSOCIATION

As a souvenir of this joint meeting of the American and Canadian Medical Associations, the C.M.A. presented to the A.M.A. a gavel, the material of which is of historic interest. The wood in the shaft of the gavel is of American walnut and the head is English oak, obtained from a pile of one of the earliest of London's wooden bridges, built about the year 1098. The pile from which the fragment was taken was removed from the River Thames in 1832. The inscriptions on the gavel are engraved on Canadian silver. The wood was a gift to the C.M.A. from Prof. C. T. Currelly, Director of the Royal Ontario Museum of Archeology, Toronto. The gavel was modelled from an old Egyptian mace. It was presented to the A. M. A. at the Monday Luncheon and was accepted by Dr. Walter Bierring, the President.

B. M. A. MEETING, MELBOURNE, AUSTRALIA, 1935

Early in the year we were advised that the British Medical Association will meet next September in Australia and that a number of the party will be proceeding via Canada. Arrangements have been completed to entertain our British visitors en route through Montreal, Toronto, Niagara Falls, Sault Ste. Marie, Port Arthur, Fort William and Vancouver.

We were cordially invited by the British Medical Association to send an official fraternal delegate to the meeting. We are glad to report that Prof. R. D. Rudolf, of Toronto, who for many years has been a member of both the British and Canadian Medical Associations, has kindly consented to act as our official delegate to Melbourne.

Approved.

THE FREDERIC NEWTON GISBORNE STARR AWARD

Various proposals have engaged the attention of your Executive Committee during the year with respect to the establishment in the Association of a fitting memorial to the late Dr. F. N. G. Starr. As is well known in Council, Dr. Starr, for a period of close upon forty years, was one of the most ardent and helpful supporters the Association has ever had. Your Committee desires to report that Mrs. Starr has graciously offered to provide an award in the form of a medal to be known as The Frederic Newton Gisborne Starr Medal, to be presented to a Canadian physician for achievement in any field of endeavour. The proposal carries with it the unanimous approval of your Executive Committee, and we would recommend to Council that it be accepted and that Mrs. Starr be thanked for her kindness and generosity in perpetuating in our Association the name of such an honoured and revered colleague as Dr. Starr.

In connection with this matter, the following communication from Mrs. Starr was read before Council:—

"When Officers of the Canadian Medical Association approached me in regard to their wish to establish in their organization a lasting memorial to the long years of strenuous, unceasing, constructive work which my beloved husband gave to the cause of organized medicine in Canada, through the finest national medical institution, the Canadian Medical Association, I was indeed deeply touched. I knew how greatly surprised and how happy my husband would be; surprised because of his modest estimate of his own achievements, and happy because of the generous thought of his colleagues.

Three suggestions were advanced. First, a Scholarship to be named for him—appropriate, as symbolizing his eager interest in students and younger members of his profession. Second, a Lectureship to be named for him. Third, a Medal to be named for him, to be awarded "For Achievement" to any member of the Canadian Medical Association who adds distinction to the profession by his attainment in science, art or literature, thus contributing to the humanitarian or cultural life of our country. This third proposal came from Western Canada, from Dr. H. H. Murphy, of Victoria, British Columbia, and in its imagination and by its beautiful tender spirit, seemed to be a fitting expression of my husband's ideals and life. Dr. Murphy's wish was that this award should be to the medical profession in Canada what the Victoria Cross is to the British Army, the highest award that organized medicine in Canada, as represented by the Canadian Medical Association, can bestow upon its recipient. This third idea was accepted by the officials of the Canadian Medical Association. The award is not necessarily bestowed annually, but when, in the judgment of the Canadian Medical Association Committee, the occasion for such distinction arises.

Realizing my husband's strong objection to appeals to members of the medical profession for money, and knowing from his experience the difficulties attending such appeals, I asked for and am given the privilege of financing this award, always realizing that in the hearts of his many friends lies his greatest memorial. The medal is to be circular of approximately an inch and a half in diameter, of gold and is designed by the distinguished designer and sculptor of Canada, Emanuel Hahn. It is in itself exquisite work quite outside of what it represents. The die is to be made in England and the award is provided for financially in perpetuity.

May the Committee of the Canadian Medical Association in charge of the awarding of this Medal always guard the ideal which this award represents and may this memorial encourage higher and ever higher standards in the profession my dear husband loved and served, for which his vision was so great and his aim so high."

(Signed) Anne C. M. Starr.

The members of Council expressed their sincere appreciation of Mrs. Starr's generosity in connection with the establishment of the Frederic Newton Gisborne Starr Award; and the working out of the details in connection with the award was referred to the Committee on Scholarships, Orations and Awards.

Radio Broadcasting

Your Executive Committee has had conferences with the Canadian Radio Broadcasting Commission in respect to the use of the air for two purposes,—(1) to broadcast authentic health information; and (2) with respect to the broadcasting of advertising which, in the opinion of your Committee frequently borders on the fraudulent. We wish to report that the Chairman of the Radio Commission is in full agreement with the recommendations of your Committee, and has expressed his willingness to provide facilities over the Canadian broadcasting stations whereby we may resume our regular radio health features. Furthermore, the Chairman is desirous that, as far as possible, there shall be kept off the air statements of a medical advertising nature which are misleading and fraudulent; and to that end the Commission is receiving the active help of the Department of Pensions and National Health in censoring a great deal of copy which is presented for advertising purposes. The increasing importance which the radio plays in the life of our people makes it necessary for us to do all in our power to prevent the use of the radio by those who would use it for selfish purposes at the expense of the health of our people. The help of members of Council and members of the profession, throughout Canada is solicited in strengthening our hands. Each one is urged to bring to the attention of the Association anything which may be helpful in keeping radio programs out of the field of quackery.

Approved.

Memorandum Concerning the Relationship of the Dominion Government to Public Health

At the meeting of Council in June, 1934, growing out of the consideration of certain changes made in the Department of Pensions and National Health, Council passed a resolution from which the following clause is quoted:—

> "The Canadian Medical Association believes that medical problems, such as maternal and child hygiene should be administered by an organization under general and immediate medical direction."

Your Executive Committee, in giving further consideration to this matter, and having regard to the fact that a Dominion Provincial Conference of Ministers of Health was to be held in Ottawa authorized the following memorandum to be presented to that Conference:—

1. That, irrespective of whether or not "National Health" is to be a separate department, it shall have as its permanent administrative officer a deputy-minister who would devote his whole time to the public health services of the Dominion.
2. That the Dominion accept responsibility for leadership in matters relating to public health.
3. That leadership shall mean planning methods whereby all citizens may have the full benefits of preventive medicine, and devising ways and means to make such plans effective, such as establishing standards for qualification of health workers.
4. That the Dominion accept as a policy the building up, in the Department of National Health, of a staff of recognized public health leaders.
5. That the Canadian Medical Association recognizes the place and value of voluntary health organizations.
6. That the Dominion accept as a policy the giving of grants-in-aid to local areas, through the provincial governments, for certain pieces of health work conducted according to a standard of service approved by the Dominion.

The Conference was held in Ottawa on April 25th and 26th, under the Chairmanship of the Honourable Dr. Sutherland, Minister of Pensions and National Health, with all the provinces but Quebec represented. The General Secretary was present by invitation and addressed the conference on the evening of April 25th. A number of resolutions of much significance to the medical profession were adopted, namely:

1. That a Royal Commission be appointed to examine into the whole question of health activities and medical service in the Dominion of Canada.
2. That the Ministers of Health of the Nine Provinces in Canada, under the Chairmanship of the Minister of Pensions and National Health of the Dominion Government be constituted as a Cabinet of Health to be called to meet periodically at the pleasure of the Honourable Minister of Health for Canada.
3. That there be established as an adjunct to this Cabinet of Health, an Advisory Committee of representatives from the various bodies qualified to be of assistance to such a Cabinet.

4. That Departments of Health, both national and provincial, constantly endeavour to engage in closer cooperation with the Medical Associations of Canada, with a view to promoting health interests in Canada.
5. That the Conference approve of grants-in-aid to voluntary health agencies, but that such agencies should confer together and present jointly their requests to Governments for money-in-aid, such grants later to be made upon the basis of the total amount of funds available compared to the total amount of the budget approved by the conference of voluntary agencies.

Throughout the entire two days of the Conference, it was abundantly clear that the Health Ministers look to the medical profession of Canada for advice and leadership in all health problems. Your Committee would recommend that Council express by appropriate resolutions its very keen desire to cooperate in every possible way with the authorities in furthering health promotion in Canada.

Approved.

In discussing the six resolutions in the first part of this report it was pointed out that, for many years, the Canadian Medical Association has laboured to cooperate to the best of its ability with the Departments of Health. The Canadian Medical Association feels that the Federal Department of Health is the public health body of Canada. An endeavour has been made to strengthen the hands of the Federal Department of Health in its endeavour to promote good health from coast to coast. There is nothing in the resolutions which interferes with the autonomy of any provincial department of health within its own area.

Addition to Our Code of Ethics

A communication was presented to your Executive Committee from the Ontario Medical Association suggesting that the Code of Ethics, Chapter B, Article 1, Clause 2, paragraph 2, be amended by adding the words,

"At all times, whether practising singly, or in groups or clinics," after the words "it is derogatory to the dignity of the profession". The clause would then read as follows:—"It is derogatory to the dignity of the profession, at all times, whether practising singly or in groups, or clinics, to resort to public advertisements . . . ."

This recommendation is passed to Council with the approval of your Executive Committee.

Approved.

At the meeting of the new Executive Committee a resolution was passed instructing the Committee on Constitution and By-Laws in conjunction with the Committee on Ethics to revise the Code of Ethics for presentation to Council next year.

Revision of By-Laws

At the Calgary meeting, the Executive Committee was instructed to arrange for the complete revision of the Constitution and By-Laws of the Association. Under the Chairmanship of Dr. Geo. S. Young, this task has engaged the attention of the Committee on Constitution and By-Laws, which Committee has reported to the Executive Committee, and the amended report is herewith appended:—

184 College Street,
Toronto 2, March 29, 1935.

To the Members of the Executive Committee:—

Since the last printing of our Constitution and By-Laws about seven years ago amendments have been made from time to time, and today we have to use copies containing nearly a dozen typewritten inserts. At least one other change has been made which has not yet found its way into the booklet. Even with the addition of these, there are still deficiencies, ambiguities and radical defects which have long been recognized but which could not easily be rectified without a complete revision.

To bring this about the Council at the Calgary meeting last June instructed the incoming Executive Committee "to make a complete revision of the By-Laws, bringing them up to date with the organization as it now exists". Acting on these instructions, a nucleus committee was formed consisting of George Young, Chairman; T. C. Routley, Secretary; M. H. V. Cameron, Roscoe Graham, Harris McPhedran and R. I. Harris, and this Committee has met weekly since last November.

At the outset members of the Executive Committee were asked to contribute their views as to advisable changes. Letters were also written to the various Provincial Medical Associations requesting suggestions. From these and other sources much valuable help has been received. Naturally there has been some diversity in the views expressed, but the same aim is evident in all the communications, *viz.*, the development of a great national organization which in its structure will adequately represent the Provincial Branches and in its function will endeavour to maintain a high standard of medical service.

In the Constitution and By-Laws now submitted many changes will be observed. The Objects of the Association as set forth in the Constitution have been stated briefly in general terms. A new classification of membership is introduced and the terms "non-resident members" and "members at large" have been added. The Constitution makes it obligatory that every Provincial Branch shall have representation on the Executive Committee. The office of Vice-President has been dropped. The Council becomes the General Council to distinguish it from the Council of certain of the Provincial Associations. The basic representation of the Provincial Associations on the General Council, *viz.*, three, has been increased to five. In other words the Provincial Associations will elect eighteen more representatives on the General Council than at present and will thus hold the balance of power in the total membership of General Council. The Committee on Inter-Provincial Relations has been dropped from the list of Standing Committees.

In the old By-Laws there is some ambiguity in regard to the control of the Annual Meeting. This, it is hoped, has been removed by a new section. Considerable change has been made in the section dealing with the appointment of the Nominating Committee and with its function, and a new section has been added for its guidance while in session. The personnel of the Nominating Committee has been increased from eleven to fifteen members, not including the President who is a member *ex-officio*. The personnel of the Executive Committee has also been increased from ten to thirteen, not including members *ex-officio*.

Sub-headings have been employed as far as possible to make reference easier, and eventually an index should be added.

The proposal for a federation of the Provincial Associations, each in this way becoming an integral part of the Canadian Medical Association, is discussed in a supplementary report submitted herewith. Your Committee is of the opinion that the Constitution should be so changed as to make some partial or complete plan of federation possible if desired by the Provincial Asso-

ciations. To this end additional clauses have been added to Article V. of the Constitution. Federation would also involve the formation of enabling By-Laws and this has engaged the attention of your Committee, but progress has not been sufficient to justify a report at the present time.

All of which, together with the accompanying Constitution and By-Laws, is respectfully submitted.

GEORGE S. YOUNG,
Chairman.

CONSTITUTION

ARTICLE I.—TITLE

This Association shall be known as The Canadian Medical Association, and, when the French language is used, it shall be known as "L'Association Médicale Canadienne".

ARTICLE II.—OBJECTS

1. The promotion of health and the prevention of disease.

2. The improvement of medical services however rendered.

3. The maintenance of the integrity and honour of the medical profession.

4. The performance of such other lawful things as are incidental or conducive to the welfare of the public and of the medical and allied professions.

ARTICLE III.—ETHICS

The Code of Ethics of The Association shall be such as may be adopted by The Association from time to time. A copy shall be supplied to all members of The Association.

ARTICLE IV.—MEMBERSHIP

The Association shall be composed of ordinary members, members-at-large, senior, non-resident and honorary members, elected by the method set forth in the By-Laws.

ARTICLE V.—BRANCH ASSOCIATIONS

Each provincial medical association is recognized as a Branch Association and shall be represented on the General Council and on the Executive Committee of The Canadian Medical Association.

Any Branch, if it so desires, may merge its identity in that of The Canadian Medical Association and become a Division. It shall then be known as The Canadian Medical Association, ... (name of Province) Division. All of its members shall be members of The Canadian Medical Association and shall be entitled to all the rights and privileges of membership.

ARTICLE VI.—AFFILIATED SOCIETIES

Any nationally or internationally organized medical, scientific or sociological body may, subject to the approval of the General Council, become affiliated with The Canadian Medical Association. Affiliation shall be understood to imply the establishment of a friendly relationship with the affiliated organization. There shall be no obligation on the part of either party to the affiliation to sponsor policies or movements on the part of the other.

ARTICLE VII.—MEETINGS

The meetings of The Association shall be held in whole or in part on such occasions as may be provided for in the By-Laws.

ARTICLE VIII.—OFFICERS

(*a*) The Patron.

(*b*) The elective officers of The Association shall be a President, a President-Elect, a Chairman of the General Council, and an Honorary-Treasurer.

(*c*) The appointive officers of The Association shall be a General Secretary and such other officers as may be appointed by the Executive Committee.

ARTICLE IX.—THE GENERAL COUNCIL

The General Council shall consist of:—

(*a*) The officers of The Association.

(*b*) The President and Secretary or Joint Secretaries of the Provincial Branches.

(*c*) Delegates elected by the Provincial Branches.

Each Branch Association shall be entitled to elect five delegates to serve on the General Council for its membership in The Canadian Medical Association of fifty or less; one additional delegate for its membership from fifty-one to one hundred; another delegate for its membership from 101 to 300; and, thereafter, one delegate for every 300 members above 300.

(*d*) Chairmen and Secretaries of Committees of The Association.

(*e*) Chairmen and Secretaries of Sections of The Association.

(*f*) Past-Presidents of The Association.

(*g*) Two representatives of the Department of Pensions and National Health.

ARTICLE X.—COMMITTEES

The Committees shall be (*a*) Standing; (*b*) Special.

(*a*) The Executive Committee shall be elected by the General Council; the other standing committees shall be appointed by the Executive Committee.

The standing committees are as follows:—

1. The Executive Committee
2. The Committee on Legislation
3. The Committee on Medical Education
4. The Post-Graduate Committee
5. The Committee on Program
6. The Committee on Constitution and By-Laws
7. The Committee on Archives
8. The Committee on Public Health
9. The Committee on Ethics and Credentials
10. The Committee on Economics
11. The Committee on Pharmacy
12. The Committee on Hospital Service
13. The Cancer Committee.

(*b*) Special Committees may be appointed by—
(i) the President
(ii) the General Council
(iii) the Executive Committee
(iv) the Chairman of the General Council.

ARTICLE XI.—FUNDS

Funds for the purpose of The Association shall be raised in such manner as may be determined by the General Council.

ARTICLE XII.—THE ASSOCIATION YEAR

The Association year shall be the calendar year.

ARTICLE XIII.—AMENDMENTS

1. Notice of Motion by individual members or others to amend the Constitution must be placed in the hands of the General Secretary six months before the date of the annual meeting.

2. Amendments may be proposed by the General Council, the Executive Committee or the Committee on Constitution and By-Laws, without notice of motion, but the proposed amendments shall be published in the *Journal* in two issues preceding the annual meeting.

3. The Constitution shall be amended by a two-thirds vote of the members of the General Council in session present and voting.

BY-LAWS

CHAPTER I.—MEMBERSHIP

Section 1—Ordinary Members

Any member in good standing in a Branch Association shall be automatically an *ordinary member* of The Canadian Medical Association provided that he (she) pays the annual fee as levied by the General Council.

Section 2—Members-at-Large

Any graduate in medicine residing in any province of Canada, who is not a member of a Branch Association shall be accepted as a member of The Canadian Medical Association on written approval presented to the General Secretary from the Executive body of the Branch Association in the province in which he (she) resides. He (she) shall be liable for the annual fee. Such members shall be designated *Members-at-Large.*

Section 3—Senior Members

Any member of The Association in good standing who has attained the age of seventy years is eligible to be nominated for senior membership by any ordinary member of The Association, but may be elected only by the unanimous approval of the members of the General Council in session present and voting. Not more than ten such senior members may be elected in any one year. Senior members shall enjoy all the rights and privileges of The Association, but shall not be required to pay any annual fee.

Section 4—Non-Resident Members

Non-resident members may be elected by the Executive Committee from regularly qualified practitioners residing outside of Canada. They shall be required to pay not more than seventy-five per cent of the annual fee.

Section 5—Honorary Members

Honorary members may be nominated by any member of The Association and shall be elected only by unanimous vote of the General Council in session present and voting. Not more than five honorary members may be elected in any one year and at no time shall the list of living honorary members exceed twenty-five. Honorary members shall enjoy all the rights and privileges of The Association, but shall not be required to pay an annua fee.

Section 6—Discipline of Members

Any member failing to conform to the Constitution and By-Laws and Code of Ethics shall be liable to censure, suspension or expulsion.

(*a*) Any member whose annual fee has not been paid on or before the 31st day of March of the current year, may, without prejudice to his liability to The Association, be suspended from all privileges of membership.

(*b*) Any member who has been found guilty of unprofessional conduct may, upon representation of the facts to the General Council, be censured, suspended or expelled from The Canadian Medical Association.

Section 7—Restoration to Membership

A member, suspended or expelled, shall not be restored to membership until all arrears of fees have been paid or such requirements, as may be determined by the General Council or the Executive Committee, have been met.

Section 8—Resignation from Membership

Membership in The Association shall automatically cease only on suspension, expulsion, or death. Resignation may be effected by giving notice in writing to the General Secretary one month before the next annual fee is due.

Section 9—Registration at Meetings

No Member shall take part in the proceedings of The Association or in the proceedings of any of the sections thereof until he (she) has properly registered and paid his (her) annual fee.

CHAPTER II.—GUESTS AND VISITORS

Section 1—Visitors from outside of Canada

Medical practitioners and other men of science residing outside of Canada may attend the annual meeting as guests of the President or of the General Council, or as visitors when vouched for by the General Secretary. They shall register with the General Secretary without payment of fee and may, after proper introduction, be allowed to participate in discussions.

Section 2—Medical Students attending Meetings

Any hospital intern or medical student, when properly vouched for, may be admitted as a visitor to the scientific meetings but he shall not be allowed to take part in any of the proceedings unless he has been specially invited by the Committee on Program to present a communication.

Section 3—Delegates from Affiliated Societies at Scientific Meetings

Two delegates from each affiliated society, one of whom shall be a member of this Association, may attend the scientific meetings.

Section 4—Delegates from Affiliated Societies at Meetings of General Council

Two delegates from each affiliated society, provided one delegate is a member of this Association, may be invited by the Executive Committee to attend meetings of the General Council. They may, at the request of the Chairman, take part in the deliberations but shall have no voting power.

CHAPTER III.—ANNUAL MEETINGS

Section 1—Time and Place of Meetings

The time and place of meetings shall be decided by the General Council, and shall be announced as early as possible.

Section 2—Arrangements for Annual Meetings

When The Canadian Medical Association meets in any province where there is a Branch Association, the meeting shall be held in conjunction with that of the Branch Association. The local arrangements shall be under the direction of the Executive Committee of The Canadian Medical Association, which may enlist the assistance of the Branch Association. The Canadian Medical Association assumes full control of the proceedings of the meeting and of all financial obligations save entertainment.

Section 3—Type of Program

The program of the meeting may consist of business sessions, general and sectional scientific sessions.

Section 4—Presiding Officer

The President or some person designated by him shall preside at all general meetings.

Section 5—Rules of Order

The Rules of Order which govern the proceedings of the House of Commons of Canada shall be the guide for conducting all meetings of The Association.

CHAPTER IV.—MEETINGS OF SECTIONS

Section 1—Sectional Scientific Sessions

The Executive Committee shall determine what scientific sections shall hold sessions at any annual meeting.

Section 2—Appointment of Sectional Officers

The Chairman and Secretary for each scientific section shall be appointed by the Executive Committee.

Section 3—Presiding Officers at Meetings of Sections

The Chairman of the Section, or some one designated by him, shall preside at all meetings of the Section.

Section 4—Duties of Secretaries of Sections

The Secretary of the Section shall keep a correct record of the transactions and shall transmit it to the General Secretary for insertion in a minute book provided for the purpose.

CHAPTER V.—OFFICERS AND EXECUTIVE COMMITTEE

Section 1—Appointment of Nominating Committee

The General Council, at the first session of the annual meeting, shall elect by ballot from among its members present a Nominating Committee of fifteen members, not including the President, who shall be *ex-officio* Chairman of the Committee.

Candidates for election to the Nominating Committee shall be named from the floor, and the list shall include the names of one or more members of each Branch Association if represented at this session.

The candidate in each province holding the highest vote of the candidates from that province shall be declared elected. The remaining members shall be declared elected by majority vote.

The election shall be decided on a single ballot. The Chairman of the General Council shall, if necessary, give the casting vote or votes.

Section 2—Duties of Nominating Committee

The Nominating Committee shall meet on the day of its election and submit to a later session of the General Council:—

1. Nominations of the following officers of The Association: a President-Elect, a Chairman of the General Council and an Honorary-Treasurer.

2. Nomination of an Executive Committee which, in addition to those who are members *ex-officio* (See Chapter VII., Section 4), shall consist of thirteen members geographically distributed as follows:—Three shall be resident in each of the two provinces in which the offices of The Association are located and one in each of the other provinces.

3. *Rules of Procedure.*—The Committee shall be called to order by the President as Chairman *ex-officio* of the Committee. In the absence of the President, the General Secretary shall convene the Committee and request the Committee to select, by open vote, the Chairman. The Committee shall then proceed to carry out its duties by open vote. In case of a tie vote, the Chairman shall have the casting vote in addition to the vote to which he is entitled as a member of the Committee. When called for, the report of the Committee shall be presented to the General Council by the General Secretary.

Section 3—Election of Officers and Executive Committee and Place of Meeting.

When the report of the Nominating Committee has been received by the General Council in session, other nominations may also be received from the floor. A ballot shall then be taken for each of the offices in turn and also for elective members of the Executive Committee by provinces in accordance with the By-Law for the guidance of the Nominating Committee, Chapter V., Section 2, paragraph 2.

CHAPTER VI.—DUTIES OF OFFICERS

Section 1—Duties of the President

The President shall preside at the general sessions of The Association and shall perform such duties as custom and parliamentary usage require. He shall deliver a presidential address. He shall be a member *ex-officio* of all committees of The Association. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.

Section 2—Duties of the President-Elect

The President-Elect shall be installed and shall assume the office of President at the first general session of the annual meeting next following his election to the office of President-Elect. He shall be a member *ex-officio* of all committees of The Association. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.

Section 3—Duties of the Chairman of the General Council

The Chairman of the General Council shall preside at all meetings of the General Council. He shall be a member *ex-officio* of all Committees and Chairman of the Executive Committee. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.

Section 4—Duties of the Honorary-Treasurer

The Honorary-Treasurer shall be the custodian of all moneys, securities and deeds which are the property of The Association.

He shall pay by cheque only. Such cheques shall be countersigned by the Chairman of the General Council or other authorized officer of The Association and shall be covered by voucher.

He shall prepare an annual financial statement audited by a chartered accountant.

He shall furnish a suitable bond for the faithful discharge of his duties. The cost of the bond shall be borne by The Association.

He may receive for his services an honorarium to be determined by the General Council. He shall be reimbursed for his legitimate travelling expenses while engaged in the business of The Association.

He shall be a member *ex-officio* of the Executive Committee.

Section 5—Duties of the General Secretary

The General Secretary shall be the Secretary also of the General Council and of the Executive Committee of The Association. He shall also be a member *ex-officio* of all Committees of The Association. He shall give due notice of the time and place of all annual and special general meetings, by publishing the same in the official *Journal* of The Association, or, if necessary, by notice to each member. He shall keep the minutes of each meeting of the General Council and the Executive Committee in separate books and shall provide minute books for the secretaries of the different sections which he shall require to be properly attested by the secretaries thereof. He shall notify the officers and members of committees of their appointment and of their duties in connection therewith. He shall publish the official program of each annual meeting. He shall perform such other duties as may be required of him by the President, the General Council or the Executive Committee. All his legitimate travelling expenses shall be paid for him out of the funds of The Association and he shall receive for his services a salary to be determined by the Executive Committee.

CHAPTER VII.—THE GENERAL COUNCIL

Section 1—Meetings of the General Council

The General Council shall meet for at least the first two days of the annual meeting of The Association and thereafter, while The Association is in session, at the call of the Chairman. Before the close of the annual meeting, it shall elect the officers and the Executive Committee and select the place for the next annual meeting, or, if advisable, for meetings up to three years in advance.

Section 2—Special Meetings of General Council

During the interval between annual meetings, the General Council shall meet at the call of the Executive Committee. For all such meetings of the General Council, due notice shall be sent to each member, stating the purpose of the meeting. The Executive Committee, if it so decides, instead of calling such meetings of the General Council, may refer important questions to the General Council and obtain its decision by means of a mail ballot. In the event of a mail ballot being taken, two-thirds majority vote shall govern.

Section 3—Duties of the General Council

The General Council shall have supervision of all properties and of all financial affairs of The Association. It shall, through its officers, conduct all business and correspondence, and shall keep a record of all meetings and the receipt and expenditure of all funds, and shall report upon same in the *Journal* after the annual meeting.

Section 4—The Executive Committee may Act for the General Council

In order that the business of The Association may be facilitated during the interval between annual meetings, the Executive Committee shall meet from time to time at the call of its Chairman and shall have all the rights and powers of the General Council. It shall conduct all necessary business. In case of a vacancy in any office on account of death or otherwise it shall have power to appoint successors.

The President, the President-Elect, the Chairman of the General Council, the Honorary-Treasurer, the General Secretary, the Editor and the Managing Editor shall be members *ex-officio* of the Executive Committee.

CHAPTER VIII.—COMMITTEES

Section 1—Duties and Powers of the Executive Committee

The Executive Committee shall hold one or more sessions before the close of the annual meeting at which it is elected. At this meeting it shall appoint chairmen of the standing committees for the ensuing year. Between the meetings of the General Council, the Executive Committee shall represent the General Council in all its business affairs and shall exercise all the rights and powers of the General Council. The Executive Committee shall report to the General Council at the annual meeting and at such other times as the Chairman of the General Council may request.

The Executive Committee may meet when and where it may determine. On the request in writing of any three members of the Executive Committee, the Chairman shall call a special meeting. Five members, exclusive of the Chairman, shall constitute a quorum for the transaction of business.

The Executive Committee shall be responsible for the appointment of the General Secretary, the Editor, the Managing Editor, the Associate Secretaries, and any other appointive officers, and shall fix their salaries.

The Executive Committee shall have charge of the publication of the official *Journal* of The Association and of all published proceedings, transactions, memoirs, essays, papers and programs of The Association.

The Editor and Managing Editor shall present annual reports to the General Council and interim reports at each meeting of the Executive Committee. The Editor shall be reimbursed for his legitimate travelling expenses incurred on Association business.

The Executive Committee may appoint Editorial Boards to assist the Editors.

The Executive Committee shall appoint the auditor and shall have the accounts of the Honorary-Treasurer audited annually, or more often if desirable, and shall make an annual report on the same to the General Council.

Each member of the Executive Committee shall be reimbursed for his legitimate travelling expenses incurred in attending meetings of the Executive Committee other than the first meeting or meetings of the new Executive Committee, which may be held before the close of the annual meeting.

Section 2—Committee on Legislation

All matters relating to medical legislation, Federal or Provincial, and all matters requiring legislative action (made or contemplated) arising within The Association, or any of its branches, or any of its committees, shall be referred to the Committee on Legislation for information and for any necessary action.

Section 3—Committee on Medical Education

To the Committee on Medical Education shall be referred all matters pertaining to medical colleges and medical education. It shall report upon the condition of medical education throughout Canada and upon any proposed change and may suggest methods for the improvement of medical education.

Section 4—Post-Graduate Committee

To the Post-Graduate Committee shall be delegated by the Executive Committee, the responsibility of carrying out the post-graduate plans of The Association.

Section 5—Committee on Program

This Committee, with the assistance of the Chairman and Secretary of each scientific section, shall have complete charge of the preparation of the program for the annual meeting.

Section 6—Committee on Constitution and By-Laws

To the Committee on Constitution and By-Laws shall be referred all matters relating to the subject before action thereon is taken by the General Council.

Section 7—Committee on Archives

The Committee on Archives shall be responsible for collecting as far as possible, (*a*) the obituaries of members dying since the last annual meeting; (*b*) all documents and information relating to the various members and activities of The Canadian Medical Association which are deemed worthy of preservation. The Editor of the *Journal* shall be a member *ex-officio* of this Committee.

Section 8—Committee on Public Health

(*a*) It shall be the duty of this Committee to place itself in communication with the official and voluntary health organizations of the Dominion.

(*b*) It shall be the duty of this Committee to keep the public informed through the various means available, on matters pertaining to health.

Section 9—Committee on Ethics and Credentials

To this Committee all matters of ethics and special questions of credentials shall be referred for consideration and report to the General Council or the Executive Committee.

Section 10—Committee on Economics

It shall be the duty of the Committee on Economics (excepting where otherwise provided) to deal with (*a*) social legislation which includes medical services or benefits presumably for medical services; (*b*) remuneration and employment of physicians by lay bodies, hospital or official bodies, including Federal, Provincial and Municipal Governments.

Section 11—Committee on Pharmacy

It shall be the duty of the Committee on Pharmacy to deal with (*a*) all matters arising out of the British Pharmacopœia or any Canadian Formulary or Pharmacopœia; (*b*) all matters arising out of the drug section of the Food and Drugs Act, the Narcotic Act, or the Patent and Proprietary Medicine Act, and (*c*) any inquiries from members of The Association relating to the use or standards of drugs.

Section 12—Committee on Hospital Service

This Committee shall act in an advisory capacity to the Hospital Service Department of The Association.

Section 13—Committee on Cancer

To this Committee shall be referred all matters relating to the study and control of cancer.

Section 14—Special Committees

Each Special Committee shall assume by direction such duties as are allotted to it and shall make progress reports to the Executive Committee at each of the meetings of that body or at any other time that such reports may be required by the President, the Chairman of the General Council, or the Executive Committee.

Section 15—Reports of Committees

Reports of all Committees shall be printed and mailed to all members of the General Council at least one week before the annual meeting.

Section 16—Limitations of Committees re Finances

No Committee shall expend any moneys or incur any indebtedness or obligation on behalf of The Association without the sanction of the Executive Committee.

CHAPTER IX.—ADDRESSES AND PAPERS

Section 1—Addresses at Annual Meeting

All addresses delivered at an annual meeting shall immediately become the property of The Association, to be published or not, in whole or in part, as deemed advisable, in the *Journal* of The Association. Any other arrangements for their publication must have the consent of the author or of the reader of the same and of the Editor of the *Journal*.

Section 2—Publication of Papers Presented at Annual Meeting

All papers, essays, photographs, diagrams, etc., presented in any section, shall become the property of The Association, to be published in the *Journal* of The

Association or not, as determined by the Editor, and they shall not be otherwise published except with the consent of the author and of the Editor of the *Journal*.

Section 3—Disposition of Papers Presented at Annual Meeting

Each author of a paper read before any section shall, as soon as it has been read, hand it with any accompanying diagrams, photographs, etc., to the Secretary of the Section before which it has been presented. The Secretary shall endorse thereon the fact that it has been read in that Section, and shall then transmit it to the Editor of the *Journal*.

CHAPTER X.—PROVISIONS FOR DISCIPLINE

Section 1—If any member of The Association, after due enquiry by the General Council or one of its Standing or Special Committees shall be judged by the General Council to have been guilty of disgraceful conduct in any professional respect, he (she) shall be liable to censure, or suspension, or expulsion from Membership in The Association by resolution of the Executive Committee, confirmed by a three-fourths vote at the next ensuing annual meeting of General Council.

Section 2—Should any Member of The Association be convicted of any criminal offence, or have his (her) name removed from the register of the Medical Council of Canada, or of the licensing body of any Province of Canada, because of felonious or criminal act or disgraceful conduct in any professional respect, the Executive Committee may, by resolution, confirmed at the next ensuing annual meeting of the General Council, by a three-fourths vote of those present, censure, or suspend, or expel such member from Membership in The Association.

Section 3—Any member suspended or expelled by resolution, as aforesaid, shall thereby forfeit all his (her) rights and privileges as a member of this Association.

Section 4—Any member suspended or expelled by resolution as aforesaid shall, subject to conditions imposed by the Executive Committee, be restored to Membership upon resolution of the Executive Committee, confirmed at the next ensuing annual meeting of General Council.

Section 5—By subscribing to the application for membership under the terms of the By-Laws and Code of Ethics and becoming a Member of The Association, every member attorns to these By-Laws and agrees to such right of discipline as aforesaid and thereby specifically waives any right or claim to damages in the event of his (her) being so disciplined.

CHAPTER XI.—AMENDMENTS

1. Notice of Motion, by individual members or others, to amend the By-Laws, must be placed in the hands of the General Secretary three months before the date of the annual meeting.

2. Amendments may be proposed by the General Council, the Executive Committee or the Committee on Constitution and By-Laws without notice of motion, but the proposed amendments shall be published in the *Journal* in two issues preceding the annual meeting.

3. The By-Laws shall be amended by a two-thirds vote of the members of the General Council in session present and voting.

Approved.

SUPPLEMENTARY REPORT

FEDERATION SCHEME

To the Members of the Executive Committee:—

Your Committee was given definite instructions to revise the Constitution and By-Laws for the organization as it now exists. At the outset, however, it was faced with the possibility of a radical change in the framework of the Association in the near future.

Out of the West came an attractive proposal for a federation of all the Provincial Associations in one great national organization to be fashioned along the lines of the British Medical Association. The Manitoba Association started the movement by generously offering to merge its identity in that of the Canadian Medical Association if the other Provinces would follow its lead. Our President, Dr. J. S. McEachern, carried the message across Canada and the idea was received everywhere with enthusiasm.

The Federation Scheme seemed too important to be overlooked and your Committee gave it a great deal of study. Certain conclusions were reached and the following report is now submitted. It concerns principles rather than details, and is presented with no thought of finality but merely as a basis for discussion now or later.

In the Federation Scheme every member of the Provincial organizations would become a member of the Canadian Medical Association. There would be at once an increase in the membership of the National Association of over 1,600. The question arises as to how this might affect the revenue of the Canadian Medical Association and also the circulation of the *Journal*. The answer would be very simple if the Provincial Associations could so increase their fees as to be able to contribute a certain adequate amount for each of their members to the treasury of the National organization. Then every member would, through this original fee, help to bear the cost of the National Association's administration and would receive the *Journal*. Under this plan the "certain adequate amount" might be considerably less than the present fee of $10.00 for membership in the Canadian Medical Association, as the following figures will show.

The present membership derived from the Provincial Associations is approximately 2,543 which at $10.00 each gives a revenue of $25,430. The total membership of the various Provincial Associations is estimated at 4,196. A per capita contribution of $8.00 would produce from these a revenue of $33,568. There would have to be charged against this the cost of the *Journal* for 1,653 extra members, and some increase in administration expenditure, but, even so, the revenue of the Association would not suffer.

The following figures do not take into account the cost of the *Journal* but show the gross gain or loss in revenue for the Canadian Medical Association if one or more Provincial Associations adopted the Federation Scheme on the $8.00 basis:—

	Gain	*Loss*
British Columbia	$ 510	
Alberta	950	
Saskatchewan	1110	
Manitoba	1030	
Ontario	3880	
Quebec		$660
New Brunswick	510	
Nova Scotia	748	
Prince Edward Island	130	

It will be noticed that the Canadian Medical Association would gain something in revenue even if only one Province (except Quebec) adopted the Federation Scheme. But would it be possible for a Provincial Association with a membership largely in excess of its present membership in the National Association to swing all its members into line for an extra contribution to the revenue of the latter body? Certainly it would be possible, just as any ideal is possible, but very difficult, even if each member received the *Journal* in return.

To avoid this difficulty it has been suggested that while in the Federation Scheme all members of the Provincial Associations would of necessity be members of the National Association, they might, insofar as National Administration is concerned, be divided into two classes:—

1. A non-contributing class who would not receive the *Journal* and who might be called "Junior Members".

2. A contributing class. These would receive the *Journal* and might be called "Senior Members". Or they might be distinguished by the terms "Members" and "Fellows".

Obviously the contributor would continue to pay $10.00 as at present and the *Journal* would be the only

visible distinguishing mark between the two classes. We do not believe that the principle of non-contributing membership is sound.

It has also been suggested that the *Journal* might be left out of account altogether and sold on a purely subscription basis. The revenue of the Canadian Medical Association would then be derived from two main sources, *viz.*, the profit on the *Journal* and a comparatively small per capita contribution from each of the Provincial organizations. It is doubtful whether the *Journal* with a monthly issue could compete with other similar publications if it charged more than $6.00 per annum. It is also open to question whether it is ready to stand entirely on its own feet. With a subscription rate of $6.00 there would probably be required a per capita contribution of between $2.50 and $3.00 from the total membership of the Provincial Associations to make up the required national revenue. This estimate is derived as follows:—

Present revenue derived from 2,543 members	$25,430
2,543 subscriptions at $6.00.....	15,258
Revenue to be made up.....	$10,172
Total Provincial Membership, 4,196—	
(*a*) At per capita rate of $2.50.....	$10,490
(*b*) At per capita rate of $3.00.....	12,588

Will the Federation Scheme have to be abandoned if one or more provinces hold back? Not necessarily. It would be quite possible to arrange an optional plan whereby Provincial Associations could come in or stay out. Those staying out would have exactly the same relation to the Canadian Medical Association as at present. Those coming in would make a per capita contribution to the National body which need not be more than $8.00 per annum and all the members would receive the *Journal*. Reference to the figures already given will show clearly that the revenue of the Canadian Medical Association would not be impaired under such an arrangement. The optional plan, while not ideal, has some points to commend it. It can be used if the provinces are not unanimous on the Manitoba proposal. The reluctant provinces would eventually come in. They would be under constant pressure both from within and without and the lower rate offered would not be the only incentive toward a closer relationship with the National organization.

Your Committee has therefore prepared Constitutions for the Federation Scheme under two plans. The one, which has been labelled for convenience the "All-or-none" plan, is the one which has been so widely accepted. It cannot come into operation unless all the Provincial Associations accept it. The other has been called the "Optional" plan, and allows the Provincial Associations to come into a Federation or stay out as they please. Your Committee is not ready to present complete Constitution and By-Laws for these two plans, but are able to suggest the following fundamental principles:—

The "All-or-None" Plan

All of the Provincial Associations are parts of the Canadian Medical Association. The word "Divisions" is preferred to "Branches". While this reverses the practice of the British Medical Association it has certain advantages. The word "Division" expresses a segment of a whole, a necessary part of an integration or federation. It indicates a change from the present situation in which the Provincial Associations exist as "Branches" to a more intimate relationship. The official designation would be "The Canadian Medical Association, (name of Province), Division."

Each Division sets its own membership fee, but includes for each member a sum to be determined by the General Council for the purpose of National Administration. It has already been noted that this contribution could be at least 20 per cent less than the present Canadian Medical Association fee of $10.00.

Each Division nominates its own representatives on the General Council, the Nominating Committee and the Executive Committee. Elections are made by the General Council.

All members are entitled to receive the *Journal* without cost.

The "Optional" Plan

A Provincial Association may, by resolution of its governing body, become either a Branch or a Division of the Canadian Medical Association.

Members of a *Branch* Association are entitled to membership in the Canadian Medical Association and to all its rights and privileges, including subscription to the *Journal*, on payment of the annual fee.

A *Division* is a Provincial Association which has merged its identity in that of the Canadian Medical Association and is known as the Canadian Medical Association, (name of Province) Division. All its members are members of the Canadian Medical Association and are entitled to all its rights and privileges, including subscription to the *Journal*. A Division sets its own membership fee, but includes for each member a sum to be determined by the General Council for National administration. Here again it has been shown that this sum could be at least 20 per cent lower than the $10.00 fee of members of Branch Associations.

Each Branch or Division has representation on the General Council and on the Executive Committee irrespective of its official status but a Division (as in the "All-or-None" plan) nominates its own representatives on the General Council, the Nominating Committee and the Executive Committee, the elections being left in the hands of the General Council.

All of which is respectfully submitted.

GEORGE S. YOUNG,
Chairman.

After a lengthy discussion of the Federation Scheme, a resolution was passed approving of the principle of federation on the Optional Plan.

Council then instructed the Executive Committee as follows:—

(1) to complete the draft of the revised Constitution and By-Laws in accordance with the suggestions approved by Council;

(2) to publish the same in two issues of the *Journal* as provided for in the present Constitution;

(3) to adopt, on behalf of Council, the Constitution and By-Laws as so revised, amended and published, and to put them into effect prior to the next annual meeting.

It was also agreed that a copy of the amended Constitution and By-Laws should be sent to each Provincial Medical Association for their information.

It was pointed out that after the present Code of Ethics has been revised and approved by Council it should be included in the printed Constitution and By-Laws.

Annual Meetings, Provincial Associations

During the month of July, 1934, the President-Elect, Dr. J. C. Meakins, together with Dr. A. Grant Fleming, the Associate Secretary, representing the General Secretary who was ill, attended the annual meetings of the Medical Associations in Nova Scotia, New Brunswick and Prince Edward Island.

During the months of September, October and November, a complete tour of Canada was made by the

President of the Association, Dr. J. S. McEachern, of Calgary, and the General Secretary.

Arrangements have been completed for a team of speakers to visit the Maritime Provinces in July of this year, while another team will visit North Western Ontario and the four Western Provinces during the month of September.

Owing to the fact that our benefactors found it necessary to withdraw, temporarily we hope, the funds which were available for extra-mural post-graduate medical education, the Association has had, practically, to withdraw from this field of endeavour. However, we have tried to keep the service alive by these annual visitations to the several provinces; and, by so doing, your Committee believes that a useful purpose has been served.

Approved.

Recommendation from the Section of Military Medicine

The following resolution was passed by the Section of Military Medicine at the Calgary Meeting:—

WHEREAS the mobilization in 1914 recruited the medical men as officers in the C.A.M.C. more or less in the order in which they applied, resulting in,

1. the denuding of the staffs of many hospitals of most of their specialists, such as radiologists, surgeons, oculists, laboratory men, etc.;
2. the serious impairment of the staffs of some of our medical colleges;
3. the almost total abolition of efficient medical and health services in many of our towns, villages and country districts.

BE IT THEREFORE RESOLVED that the Canadian Defence Council be asked to devise some such plan as the following, which would automatically begin to function as soon as mobilization is ordered in the future:—

1. That the Canadian Medical Association nominate annually two medical men of high repute and influence in each Military District, to act with the District Medical Officer as a Committee of Three, to advise in the recruiting of Officers for the C.A.M.C.
2. That this Committee shall be held responsible for recommending suitable medical men to fill the requirements of the Army, and also to leave suitable and sufficient medical personnel to carry on successfully the civil hospitals, the medical colleges and the civil, medical and health work of the District.

The Department of Militia and Defence, Ottawa, has approved the suggestion.

This is passed to Council for the necessary action.

The following were suggested by the Section of Military Medicine to constitute the Advisory Committees to the Department of National Defence:—

British Columbia—Major G. Ernest Gillies, Vancouver; Major Thomas McPherson, Esquimalt.

Alberta—Lieut.-Col. A. C. Rankin, C.M.G., Edmonton; Lieut.-Col. Geo. R. Johnson, V.D., Calgary.

Saskatchewan—Lieut.-Col. T. M. Leask, Moose Jaw; Lieut.-Col. E. A. McCusker, M.C., Regina.

Manitoba—Lieut.-Col. F. A. Young, O.B.E., V.D., Winnipeg; Lieut.-Col. J. A. Gunn, C.B., O.B.E., V.D., Winnipeg.

Ontario—Major-General J. T. Fotheringham, C.M.G., V.E., Toronto; Lieut. Col. J. E. Davey, D.S.O., Hamilton.

Quebec—Lieut.-Col. A. T. Bazin, D.S.O., Montreal; Lieut.-Col. P. Z. Rhéaume, C.M.G., V.D., Montreal.

New Brunswick—Lieut.-Col. D. C. Malcolm, M.C., Saint John; Major A. S. Kirkland, Saint John.

Nova Scotia and Prince Edward Island—Major Kenneth A. MacKenzie, Halifax; Lieut.-Col. J. S. Jenkins, D.S.O., V.D., Charlottetown.

Approved.

Complimentary Journals to Medical Men in Unemployment Camps

Some months ago, the attention of the Executive Committee was called to the fact that the Federal Government employs a number of full-time medical men in relief camps throughout Canada. It was pointed out that these men are apt to get very much behind the times as far as their medical work is concerned, as they are shut off from the world and cannot afford to subscribe to medica l journals to any great extent. It was recommended that the *Canadian Medical Association Journal* be sent to the nine full-time medical men in these camps with the compliments of the Association. This action was taken and replies in each instance would indicate that the *Journal* is very highly appreciated.

Approved.

King George V Silver Jubilee Cancer Fund for Canada

His Majesty, King George V, has graciously approved of the establishment in Canada of a cancer fund to be known as the King George V Silver Jubilee Cancer Fund for Canada, to recognize the silver jubilee anniversary of his accession to the throne. The fund is to be administered by a board of seven trustees upon which the Canadian Medical Association has been given representation through its Study Committee on Cancer of which Dr. A. Primrose is Chairman.

Approved.

This matter was dealt with fully in connection with the Report of the Study Committee on Cancer which appears later.

Health Insurance

The Report of the Committee on Economics deals specifically with the problem of Health Insurance in Canada. As additional information your Executive Committee desires to report that the Canadian Life Insurance Officers' Association has advised us that they are prepared to cooperate with the Canadian Medical Association in making an actuarial survey in Canada in such area as may be determined upon for the purpose, to obtain actuarial data which would be essential in connection with any health insurance scheme that might be promulgated. Your Committee desires to record its appreciation of this offer on the part of the Canadian Life Insurance Officers' Association, and to state, further, that no health insurance scheme for Canada can be looked upon as economically sound unless it is based upon actuarial data secured in our own country.

Approved.

Medical Relief

The attention of your Committee has been called to the fact that in the majority of the Provinces of Canada, medical relief to the unemployed and their dependents is very largely being carried on gratuitously by the medical profession. In the Province of Ontario, the Government has handed over to the Ontario Medical Association the complete administration of medical relief in that province. The Government has provided 25c for each person on relief per month in old Ontario and 50c for each person on relief per month in new Ontario. Close upon ninety medical relief committees have been appointed, each committee consisting of at least three doctors, one druggist and the relief officer for the area. It is the duty of each committee to scrutinize and approve all doctors' accounts for the district and then to forward a summary of each doctor's account to the Central office of the Ontario Medical Association. Cheques are then issued by the O.M.A. to each doctor for his share of the money available for the area. In all cases of dispute, the ruling of the local Medical Relief Committee is final. The money received from the Government is kept for each municipality and the doctors' accounts will be pro rated according to the amount of money available for the area. Each

doctor is responsible for his own drug account. He may either settle directly with the druggist or, if he prefers, have it deducted from the amount due him for medical services.

The amount of money available for medical relief services is said to be inadequate, especially in old Ontario; but it is hoped that, after a trial period of several months, the Medical Association will be in possession of statistics which will be very valuable in future approaches to the Government. The lack of statistical data in the past has been a great detriment in conferences with Governments with regard to fair fees for services rendered.

Approved.

Grant to the Department of Publicity and Health Education

A communication has been received from the Canadian Life Insurance Officers' Association announcing a grant of $6,000 to the Department of Publicity and Health Education for the year ending June 30th, 1936. Your Committee recommends to Council that a suitable resolution of appreciation be tendered to the Canadian Life Insurance Officers' Association for this further evidence of their active interest in and support of our activities.

Approved.

Grant to the Department of Hospital Service

Your Committee has recently been advised by the Sun Life Assurance Company of Canada that $12,000 will be available for the work of the Department of Hospital Service for the current year. Your Committee recommends that this generosity on the part of the Sun Life Assurance Company be acknowledged by a suitable resolution from Council.

Approved.

Future Annual Meetings

Invitations for future annual meetings are in hand from Victoria, London, Ottawa, Montreal and Halifax. These communications will be submitted to the Committee on Nominations for the necessary action.

In discussing this section of the report, the feeling was expressed that annual meetings should be held more frequently in central Canada, particularly in Montreal and Toronto. In this connection it was pointed out that we have a Committee, under the Chairmanship of Dr. Patch, whose duty it is to study suitable places for annual meetings of The Association. This Committee will report at the autumn meeting of the Executive Committee.

Attention was called to the fact that, at the annual meeting in Calgary in 1934, it was agreed that the President should not necessarily be selected from the place at which the meeting is to be held, and that this should be borne in mind in future, inasmuch as there are many very active members of The Association deserving of the honour of election to the Presidency who reside in small places where it would be impossible to hold an annual meeting.

Conclusion

In addition to the foregoing items, a great many matters of lesser importance have engaged the attention of your Committee and Officers during the year. Your Committee is of the opinion that the influence of the Canadian Medical Association increases from year to year, and would strongly urge that all possible steps be taken by our component Branches to strengthen the Association in order that it in turn may more adequately serve the profession as a whole.

All of which is respectfully submitted.

GEORGE S. YOUNG,
Chairman.

T. C. ROUTLEY,
General Secretary.

Approved.

The complete report of the Executive Committee as amended was then approved.

REPORT OF THE DEPARTMENT OF HOSPITAL SERVICE

Mr. Chairman and Members of Council:—

During the past year the Department of Hospital Service has been enabled to continue to the hospitals and their staffs what would appear to be a much appreciated service for requests for information and advice have steadily increased in number since the organization of this Department. Our carefully indexed files on hospital data and procedure, while still far from complete, comprise the most complete library on hospital work in this country and the material and services of the Secretary are available to any hospital group. It is of interest that during the last two or three years requests for help in construction have fallen off, but there has been a definite increase in the study of possible economies in administration, in betterment of organization and in social legislation and service to the community.

During the past year Canada has been visited from coast to coast, and addresses on hospital, nursing and allied health topics have been given in the various provinces. Articles on hospital topics have been contributed to various journals as frequently as time would permit and numerous studies of interest to hospital workers have been made. These have included studies on organization, technical and administrative procedure, nursing, economics and costs, medical relationships, legislation and other subjects.

Approval of Hospitals for Internship

At the present time 38 hospitals with 557 internships have been "approved" for internship and 13 hospitals with 49 internships have been placed upon the "recommended" list. This indicates an increase of 98 approved internships over the number listed a year ago. The Committee on Approval has been very careful in its decisions and the improvement in the services in many of the hospitals listed has been very obvious. Of some concern is the increasing shortage of interns. For a total of 606 Canadian internships approved or recommended there are graduated in Canada some 475 medical students, and of these far from all are available for internship in this country. Various factors modify the balance of supply and demand but each year the shortage seems to be more obvious and some readjustment will soon become imperative in many hospitals.

The Canadian Hospital Council

This federation of provincial and other hospital associations, of the various governments and of our Department of Hospital Service has already so proved its value to the hospital field and to the patients whom they serve that funds have been provided by the hospital associations during the past year to permit additional personnel in this office to handle the increasing demands and to permit greater distribution of studies, reports and other data. This has been welcome as the limited staff of this Department has found it quite impossible to adequately handle the work presenting. The biennial meeting will take place this year in Ottawa on October 8th and 9th. The reports on Medical Relations and on Small Hospitals will be of particular interest to the medical profession.

GROUP HOSPITALIZATION

This and allied developments have been followed closely by this Department as it is evident that the general public is becoming increasingly interested in this trend. The report of the special committee on this subject appears elsewhere in these pages. Our Department has had the opportunity to proffer counsel to a number of groups interested in launching these plans and it is hoped that the information so passed on will prove of benefit.

RADIOLOGISTS AND HOSPITALS

The relationship of radiologists to hospitals has been a matter of considerable discussion in both Canada and the United States. Our Radiological Section requested the Secretary of this Department to give some consideration to this subject and as a result considerable correspondence and several conferences have taken place. During the past year, and as a result particularly of a conference with representatives of the radiologists, of the American Medical Association and of the American Hospital Association, the situation has been considerably clarified although, because of the complexity of the situation, an early and fully satisfactory solution to the problem cannot be anticipated.

THE MEDICAL STAFF

During the past year there has been continued interest in improving the medical services in hospitals. Quite a number of hospital staffs have found their basis of organization obsolete or inadequate and have undertaken its revision. Staff meetings and conferences are being reorganized. The financial difficulties of the hospitals have made the doctor more "hospital-minded" and the increased burden on the doctors has made the hospitals still more sympathetic. It is felt that there is a need for the establishment of a code of professional ethics appertaining to *hospital practice* and the early setting up of such code would seem desirable. The provision of adequate pathological and radiological services in the smaller hospitals is being given serious attention at the present time. The continued financial depression has resulted in many families now patronizing the public ward, whereas formerly they preferred private accommodation. This has again brought forward the question of public ward privileges and has made it a major issue in more than one hospital centre.

Sincere thanks are extended to Dr. A. K. Haywood and the members of the Hospital Committee, to the Advisory Committee (largely lay workers—administrators, nurses, architects and others), and to the many hospital workers in various activities whose cooperation has been so helpful. Close and cordial relationships have been established with the various governmental departments and with the national and international associations serving the hospital field. We acknowledge with grateful thanks continued support of the hospital reference library (the Blackader Library) by Mrs. A. D. Blackader. To the Sun Life Assurance Company of Canada whose continued interest and support has made it possible for this Association to carry on this service to the hospitalized citizens of Canada our especial thanks are extended.

All of which is respectfully submitted.

G. HARVEY AGNEW,
Secretary.

Approved.

Several members of Council expressed their appreciation of the work being done by the Department of Hospital Service of The Association.

REPORT OF THE COMMITTEE ON PUBLIC HEALTH AND MEDICAL PUBLICITY

Mr. Chairman and Members of Council:—

Health education as a means of promoting public welfare has come to be accepted as a function of all organizations interested in public health.

The Committee on Public Health and Medical Publicity maintained its regular services during the past year. One French-language newspaper wrote in and asked for the Health Service. The total number of French newspapers using the service is 26; the total number of English papers is 345.

The correspondence has continued at about the same level, but somewhat above the previous year, a total of 1,631 letters having been answered during the year 1934.

Following upon a careful consideration of the need, the Health Service entered into an arrangement with the Macmillan Company of Canada to publish a series of booklets on medical and health subjects, under the general title of "What You Should Know About—." These booklets will be offered to the public at the price of twenty-five cents each, and will be on sale in book shops and in the book sections of departmental stores. If the sale shows a demand, we shall continue to publish three or four books a year, gradually building up a complete set.

A definite effort has been made this year to secure the views of members of the Committee in the various provinces. It would be desirable to extend our usefulness within the limits imposed by our budget and personnel. Just as a statement was prepared as a basis for the Canadian Medical Association's stand with regard to the proper field of service for the Department of National Health, so might we explore other fields and advise regarding the problems they present.

As in past years, the Health Service wishes to express its appreciation to the Canadian Life Insurance Officers' Association for continued interest and financial support.

The Committee is greatly indebted to the Associate Secretary, Doctor Grant Fleming, for his fine work in directing the activities of the Health Service, and to his assistant, Miss M. McCrory.

All of which is respectfully submitted.

J. G. FITZGERALD,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON SPECIALISTS

The following report of the Committee on Specialists was here presented for the consideration of Council.

A meeting of the Committee on Specialists appointed at the Annual Meeting of the Canadian Medical Association in Calgary in June, 1934, was held in the Medical Building, University of Toronto, on October 23rd, at 5 p.m., with the following members present:—Dr. E. S. Ryerson (in the Chair), Drs. Primrose, FitzGerald and D. Graham, and, by courtesy, Drs. W. E. Gallie, of Toronto, and J. Gunn, of Winnipeg.

The chairman presented a proposal for the control of specialists in Canada. After discussion, it was moved by Dr. FitzGerald and agreed that the outline presented by Dr. Ryerson be sent on to the Executive Committee for their consideration. This outline reads as follows:—

PROPOSAL FOR THE CONTROL OF SPECIALISTS IN CANADA

1. The Medical Council of Canada is the organized body under which should be placed the supervision of the qualification and certification of Specialists. This body is proposed because it is representative (*a*) of the medical profession, having three members chosen from the profession at large and appointed by the Governor-in-Council; (*b*) of the provinces, having two members representing

each province, who are elected under regulations made by the provincial medical councils; (*c*) of the universities, having one member from each university engaged in the active teaching of medicine; and of the homœopathic practitioners, having three members elected by them. It is an actively functioning body at present conducting examinations with the object of determining that a graduate in medicine is qualified to practise.

2. It is proposed that the Medical Council of Canada should establish and appoint boards of examiners at each of the various centres (as required) for the purpose of conducting examinations in each of the specialties.

3. It is proposed that those practitioners who pass these Specialist Examinations be granted a diploma or certificate of qualification by the Medical Council of Canada.

4. It is proposed that before he will be eligible to write on these Specialist Examinations a candidate will be required to present "an enabling certificate", which he will obtain from his own Provincial Medical Council. This certificate would state that the candidate has fulfilled certain minimum educational requirements relating to his post-graduate education and training in the particular specialty in which he desires to be examined.

5. It is proposed that a Specialist Diploma or Certificate be granted by the Medical Council of Canada to those practitioners who have successfully passed the Specialist Examinations and that a Register of qualified Specialists be published by the Council.

6. The Medical Council of Canada would have to make certain provisions for the acceptance of qualifications that would be considered as equivalent to the fulfilment of the Specialist requirements of the Dominion and Provincial Councils. The qualifications of the Royal Colleges of Great Britain or Canada, or of higher University degrees might be dealt with in this manner.

The adoption of the above proposal for specialist control would necessitate an amendment to the Canada Medical Act, using phraseology similar to that defining the purposes of the Council in the present Act, a Section of the following type would be added:—

"The purposes of the Council are also to promote and effect

(*a*) The establishment of a qualification for the specialties in medicine, such that the holders thereof shall be acceptable to practise their particular specialty in all the provinces of Canada;

(*b*) The establishment of a register of specialists for Canada, and the publication and revision from time to time of such register;

(*c*) The determination and fixing of the qualification and conditions necessary for registration as a specialist, the examinations to be undergone with respect to the subjects of their particular specialty only, and generally the requisites for registration;

(*d*) The establishment and maintenance of boards of examiners for examinations and granting of diplomas of qualification in each of the specialties."

The introduction of the above proposal of placing the control of the qualification of Specialists under the Medical Council of Canada would result in throwing certain responsibilities on Provincial Medical Councils, on medical faculties in the Canadian Universities, on the Canadian and Provincial Associations, on the medical profession in general practice, and on the members of the profession practising in the Specialties.

A.—PROVINCIAL MEDICAL COUNCILS.

1. Each Provincial Council would have to endorse the principles of the above proposal agreeing to the supervision of the qualification of Specialists being placed under the Medical Council of Canada.

2. Each Provincial Council would consider the applications of practitioners who desire to take the Specialist Examinations, and determine whether the applicant has fulfilled the minimum educational requirements by post-graduate study and training, and, if he has, issue an Enabling Certificate authorizing him to take the Specialist Examinations of the Medical Council of Canada.

3. The Councils might make regulations regarding the use of Specialist Certificates in their Province.

B.—MEDICAL FACULTIES IN THE CANADIAN UNIVERSITIES.

Facilities would have to be provided by the universities to enable practitioners to fulfil the educational requirements laid down by the Councils and to pass the Specialist Examinations. In order to acquire an adequate knowledge of the particular part of the scientific subjects, Anatomy, Physiology, Biochemistry, Pathology and Bacteriology, which are applicable to any special field of practice, the candidate might be provided with facilities to study any of these subjects in every one of the Canadian Universities.

The Universities would also have to provide facilities in their Hospitals for candidates to acquire a thorough practical training and extensive clinical experience in the special fields of practice. Such facilities are only available in the larger centres of population and bigger universities, where a great number and wide variety of cases are found.

Post-graduate degrees or diplomas might be established in some Universities, the attainment of which would be an indication of the fulfilment of a high standard of training and education in the Specialties.

Universities might at some time in the future restrict appointments to positions on their staffs and in their hospitals to practitioners who hold some recognized qualifications for Specialists.

C.—CANADIAN, PROVINCIAL AND LOCAL MEDICAL ASSOCIATIONS.

Medical Associations should endorse the principles of specialist control as proposed and urge their members to recognize the importance of a minimum educational standard for those practising the specialties. They should educate the public to the necessity for an adequate training and education for those who desire to practise a specialty.

They should endeavour to influence Boards of Directors of the Hospitals in their district to restrict their future appointments in the special branches to those who are qualified and registered as Specialists.

D.—MEMBERS OF THE PROFESSION IN GENERAL PRACTICE.

When a practitioner announces himself as a "Specialist" at the present time, general practitioners have no way of knowing whether he has had adequate post-graduate training and is fully qualified to practise his specialty. The introduction of the proposed control by the Medical Council of Canada would result in the publication of a Register of Specialists in which would appear the names of those who have been certified as fulfilling certain educational standards and as passing a Specialist Examination. Patients and the public would become educated to ascertain whether or not a Specialist is qualified to practise his specialty.

E.—SPECIALISTS IN PRACTICE AND THEIR ASSOCIATIONS.

Specialists should endorse the principles included in the proposal, as it is a means of maintaining a high standard of efficiency among Specialists. Specialists in each of the Specialties (as required) would be appointed as examiners at each of the centres where examinations are conducted. They would examine the candidates in their specialty, to determine whether or not they are qualified to practise in this specialty.

They should endeavour to influence Boards of Directors of the Hospitals in their district to restrict their future appointments to those who are qualified and registered as Specialists.

They might maintain a high standard in their Specialist Associations by requiring that admission to membership would be dependent upon being listed in the Register for Specialists.

The protection of the public is the main reason for the present licensing system for practitioners in each of the Provinces. The determination of those who are licensed is based on the fulfilment of certain minimum educational requirements and the passing of a licensing examination, either Dominion or Provincial. In this manner every licensed practitioner is recognized by the public and by the profession as qualified to practise. In the same manner the protection of the public is the main purpose for the introduction of some system of control of the practice of the Specialties of Medicine. The suggestion is made that the determination of those who are qualified to practise the Specialties should be based on the fulfilment of certain minimum educational requirements and the passing of a Specialist examination, under the supervision of the Medical Council of Canada.

Any attempt to have legislation introduced or regulations adopted for the purpose of preventing a general practitioner from undertaking any practice of a "Specialist" character, or a "Specialist" from doing any general practice, is fore-doomed to failure because of the impossibility of its enforcement and of the possibility of its preventing a practitioner from doing what he may deem essential for the patient and thereby denying to the patient the necessary treatment for his condition. The chief aim in licensing practitioners and in devising any system for the control of specialists is to guarantee to the patient that the practitioner or specialist he consults, is qualified to undertake the type of practice which he announces to the public by his nameplate, card or letter-head.

Any graduate in medicine who fulfils the minimum educational requirements and passes a Specialist examination in any special field, is entitled to undertake both general practice and practice in this special field, and any legislation for the purpose of restricting him to either one or other of these forms of practice would not be sound in principle, or meet with the approval of the profession or of the public.

If the protection of the public from the unqualified Specialist is accepted as the basic principle in the control of specialization, then all of the arguments justifying the protection of the public from the unqualified practitioner by the present systems of licensure can be used to justify any scheme that is devised for the control of Specialists.

A practitioner of medicine entitled to call himself a "Specialist" is one (*a*) who has fulfilled certain minimum educational requirements in the special field of practice which he is desirous of practising, along with the attainment of a superior knowledge in the fundamental subjects (anatomy, physiology, biochemistry, pathology, etc.) which underlie diagnosis and treatment in this special branch of practice; and (*b*) who has successfully passed a "Specialist" examination conducted for the purpose of determining whether or not he is adequately qualified to practice in this special field of practice.

In order that the public including the profession may know that a practitioner who calls himself a "Specialist" has fulfilled the above requirements and is qualified to announce himself as a specialist, there should be published a Register or List of Specialists who have fulfilled these requirements. This register should be available for consultation by both the public and the profession. The practitioners whose names appear in this Register should be in possession of a Certificate or Diploma stating that they are qualified to practise the Specialty specified. (It is not considered advisable at present for Provinces to license "Specialists" in a manner similar to the licensure of practitioners.)

In connection with this report, the following telegram was read from the Regina and District Medical Association:—

"Last night the Regina and District Medical Society passed the following resolution and the members particularly urged the Canadian Medical Association to arrive at a definite settlement of this important problem at this year's meeting. It is the opinion of this Society that the Canadian Medical Association should take steps to see that the necessary organization is set up to qualify and license all Specialists."

After a lengthy discussion of the report, it was finally adopted in principle and referred to the Executive Committee with instructions that it be brought to the attention of all bodies interested.

At the meeting of the Executive Committee held subsequently it was agreed that a copy of the report should be sent to each of the Provincial Medical Associations, the Provincial Licensing Bodies, the Medical Council of Canada, the Committee on Legislation of the C.M.A., the Medical Schools of Canadian Universities, Specialist Medical Societies in Canada and the different Sections of the C.M.A.

REPORT OF THE HONORARY-TREASURER

Mr. Chairman and Members of Council:—

I have the honour to submit the report of the Honorary-Treasurer for the year ended December 31, 1934. The accounts have been audited by Messrs. Clarkson, McDonald, Currie & Co., whose statements are attached.

It is with regret that I have to report a deficit on the year's operations of $2,540.80. This is due largely to an increase in general expenses. The revenues for the year were almost identical with those of the previous year. The reduction in membership fees of $2,500.00 was offset by increased revenue from subscriptions and advertising.

The surplus account of the Association has, as a result of the deficit, been reduced to $74,346.09.

INVESTMENTS

With one exception, a bond which was donated, all the funds of the Association are now invested in trustee securities. The few in our portfolio which did not come under that heading have now been transferred to trustee securities. While this transaction resulted in a loss, it is felt that the invested funds are now in a much more satisfactory condition.

The following changes were made in securities during the calendar year.

GENERAL FUND

$2,000	City of Toronto	4½%,	1942,	bought	Mar.,	1927,	at $	96.75,	sold at $	97.125;	replaced by—
$2,000	City of Montreal	4½%,	1947,				"	92.81			
$7,000	Canadian National Railway	4½%,	1951,	"	Sept.,	1931,	"	98.50	and		
$2,000	" " "	4½%,	1951,	"	Nov.,	1932,	"	99.75,	sold "	103.00;	" "
$9,000	Dominion of Canada	4½%,	1958,	"			"	101.00			
$5,000	Montreal Tramways	5 %,	1941,	"	Dec.,	1930,	"	99.25,	" "	101.00	" "
$5,000	Prov. of Quebec Jewish Hosp.	5 %,	1946,	"			"	99.00			
$2,000	Montreal Tramways	5 %,	1955,	"	April,	1930,	"	97.00,	" "	73.50;	replaced (Mar., 1935) by—
$1,000	Province of Saskatchewan	4 %,	1954,	"			"	90.00	and		
$ 500	City of Montreal	6 %,	1944,	"			"	108.50			
$5,000	Dominion of Canada	5½%,	1934,	"	Dec.,	1932,	"	101.45,	sold "	100.25;	replaced by—
$5,000	Dominion of Canada (Refunding Loan)	3½%,	1949,	"			"	96.50.			

INTEREST ON BANK DEPOSITS

Advice was received from the Bank of Montreal that owing to increasingly low rates of interest obtainable upon short term monies, the rates on interest bearing current accounts have been revised downwards. Since November 1st, therefore, the rate of credit on our current account has been 1 per cent on the minimum monthly balance in excess of a free balance of $2,500.00.

TRUST FUNDS AND SPECIAL GRANTS

The conditions of the Trust Funds and Special Grants will be seen in the auditors' report and no further statement is necessary, except with reference to the Osler Memorial Fund.

The Montreal Tramway bonds, a non-trustee security, the sale of which was authorized by Executive Committee, were disposed of in December, namely,

$1,000 Montreal Tramways..... 5 %, 1955, bought Jan., 1929, at $100.25, sold at $73.50
$1,500 " " ..... 4½%, 1955, " July, 1930, " $90.50 and $87.50; sold at $68.00.

They were replaced (in March, 1935) by—

$2,000 City of Winnipeg..... 4½%, 1958, bonds at $99.50.

A $50.00 bond of the Dominion of Canada, November 1, 1934, issue, 5½%, was held in this fund. On the date of expiry a $100.00 bond of Dominion of Canada, 1949 issue, 3½%, was purchased.

All of which is respectfully submitted.

F. S. PATCH,
Honorary-Treasurer.

AUDITORS' REPORT

DR. FRANK S. PATCH,
Honorary-Treasurer,
Canadian Medical Association,
3640 University Street, Montreal.

Dear Sir:—

We beg to report that we have completed an audit of the books and accounts of the Association for the year ended 31st December, 1934, and we attach the following:—

Statement No. 1.—Balance Sheet as at 31st December, 1934.
Statement No. 2.—Statement of Revenue and Expenditure for the year ended 31st December, 1934.
Schedule No. 1.—Schedule of Investments as at 31st December, 1934.
Schedule No. 2.—Schedule of Trusts and Trust Funds as at 31st December, 1934.
Schedule No. 3.—Schedule of Special Grants and Special Grant Funds as at 31st December, 1934.

The receipts and disbursements of the General Secretary in Toronto as shown on a statement, certified to by Mr. Dignam as Auditor, have been incorporated in the books.

We verified the cash on hand and in bank and received confirmation of the securities which are held in safekeeping for Investment Account and for Trusts.

We found the books and accounts in excellent order and were given every assistance in the conduct of our audit.

Subject to the above remarks, we report that, in our opinion, the attached Balance Sheet is properly drawn up so as to exhibit a true and correct view of the state of the Association's affairs as at 31st December, 1934, according to the best of our information and the explanations given to us and as shown by the books.

Yours faithfully,

(Signed) CLARKSON, MCDONALD, CURRIE & Co.,
Chartered Accountants.

STATEMENT No. 1

BALANCE SHEET AS AT 31st DECEMBER, 1934

ASSETS

Cash on Hand:			
Montreal	$25.00		
Toronto:			
General Funds	24.96		
		$ 49.96	
Cash in Bank:			
Montreal	$22,911.68		
Toronto:			
General Funds	2,044.05		
Annual Meeting	3,947.78		
		$28,903.51	
			$28,953.47
ACCOUNTS RECEIVABLE:			
Advertising		$1,206.82	
Reprints		456.94	
			$ 1,663.76
INVESTMENTS:			
At Book Value, Schedule No. 1		$61,545.75	
Accrued Interest on Investments		559.57	
			$62,105.32
Deferred Charges			211.20
Trust Funds as per Schedule No. 2			31,067.05
Special Grant Funds as per Schedule No. 3			3,892.56
Furniture and Fixtures—less depreciation			732.52
			$128,625.88

LIABILITIES

Accounts Payable and Advertising Prepaid			$ 2,236.71
Prepaid Membership Fees, 1935		$16,314.00	
Prepaid Subscriptions, 1935		769.47	
			$17,083.47
Trusts as per Schedule No. 2			31,067.05
Special Grants as per Schedule No. 3			3,892.56
SURPLUS ACCOUNT:			
Balance at Credit, 1st January, 1934		$77,006.89	
Deduct:			
Net Loss from Sale of Investments	$ 120.00		
Excess Expenditure for year as per Statement No. 2	2,540.80		
		$2,660.80	
			$74,346.09
			$128,625.88

Submitted subject to our report of this date.

(Signed) CLARKSON, MCDONALD, CURRIE & Co.,
Chartered Accountants.

STATEMENT No. 2

STATEMENT OF REVENUE AND EXPENDITURE FOR YEAR ENDED 31st DECEMBER, 1934

REVENUE

Membership Fees	$24,589.50
Subscriptions	2,781.05
Advertising	26,776.49
Special Reprints	190.76
Sundry Sales of Journal	283.79
Excess Revenue from Annual Meeting	226.05
Revenue from Investments and Bank Interest	3,193.88
Sale of Motor Emblems	4.50
Excess Expenditure for Year—Transferred to Surplus Account as per Balance Sheet	2,540.80
	$60,586.82

EXPENDITURE

JOURNAL EXPENSES:		
Printing	$22,909.92	
Illustrations	818.58	
Agent's Commission	3,048.14	
Editorial Salaries	7,422.00	
Editorial Expenses	1,590.74	
		$35,789.38
ADMINISTRATION AND FINANCIAL EXPENSES:		
General Expenses	$ 460.04	
Travelling Expenses	4,872.08	
Office Expenses—General Secretary	782.84	
Postage	897.78	
Salaries—General Secretary	8,190.00	
Other	7,690.60	
Stationery and Printing	434.68	
Telephone and Telegrams	343.49	
Bad Debts	6.89	
Committee on Economics	321.74	
Discount and Exchange	715.91	
Depreciation of Furniture and Fixtures, 10%	81.39	
		$24,797.44
		$60,586.82

SCHEDULE No. 1

SCHEDULE OF INVESTMENTS AS AT 31st DECEMBER, 1934

GENERAL FUND

	Par Value	*Book Value*
Canadian National Railway 4½/54	$3,000.00	$2,896.50
City of Montreal 4½/46	1,000.00	975.00
City of Montreal 4½/47	2,000.00	1,856.20
City of Montreal 5/54	5,000.00	5,050.00
City of Winnipeg 4½/50	4,000.00	3,871.20
Dominion of Canada 5/43	5,100.00	5,010.75
Dominion of Canada 3½/49	5,000.00	4,825.00
Dominion of Canada 4½/58	9,500.00	9,580.00
Island of Montreal Metropolitan Commission 5/49	2,000.00	2,006.00
Jewish Hospital Campaign Committee Inc. of Montreal 5/46	5,000.00	4,950.00
Province of Ontario 4½/39	1,000.00	986.30
Province of Ontario 5/48	2,000.00	2,035.00
Province of Ontario 4½/50	5,000.00	4,950.00
Province of British Columbia 4/57	5,000.00	4,775.00
Province of New Brunswick 4¾/36	1,000.00	1,003.80
Province of Quebec 4½/63	2,000.00	1,970.00
Province of Saskatchewan 4½/45	1,000.00	970.00
Province of Saskatchewan 4½/60	3,000.00	2,835.00
Ritz Carlton Hotel Co., 1st Mortgage 5/42	1,000.00	1,000.00
	$62,600.00	$61,545.75

Approximate Market Value, $64,591.50.

TRUST FUNDS

LISTER CLUB FUND:

City of Winnipeg 5/43	$4,000.00	$4,021.20
Province of Quebec 4½/63	1,000.00	985.00
	$5,000.00	$5,006.20

Approximate Market Value, $5,115.00.

OSLER MEMORIAL FUND:

Dominion of Canada 4½/57	$ 900.00	$ 918.00
Dominion of Canada 4½/58	500.00	490.00
Dominion of Canada 3½/49	100.00	96.50
Pacific Great Eastern Railway 4½/42	1,500.00	1,492.95
	$3,000.00	$2,997.45

Approximate Market Value, $3,097.75.

OSLER SCHOLARSHIP FUND:

City of Quebec R.C. Schools 5/55	$10,000.00	$10,003.00
Montreal Protestant Schools 5/52	2,000.00	1,995.60
	$12,000.00	$11,998.60

Approximate Market Value, $12,290.00.

BLACKADER LECTURE FUND:

Dominion of Canada 4½/46	$ 200.00	$ 195 00
Dominion of Canada 4½/57	200.00	204.00
Province of Alberta 4½/56	1,000.00	1,000.30
Three Rivers R.C. Schools 5½/44	3,000.00	3,030.00
	$4,400.00	$4,429.30

Approximate Market Value, $4,477.00.

SCHEDULE No. 2

SCHEDULE OF TRUSTS AND TRUST FUNDS AS AT 31st DECEMBER, 1934

			Trust Funds	*Trusts*
LISTER CLUB FUND:				
Capital		$5,042.36		
Accumulated Revenue, 1st January, 1934	$452.73			
Revenue for Year	253.90			
		$706.63		
				$ 5,748.99
Represented by—				
Investments as per Schedule No. 1		$5,006.20		
Cash in Bank		742.79		
			$ 5,748.99	
OSLER MEMORIAL FUND:				
Capital, 1st January, 1934	$5,308.92			
Add—Subscription received during year	34.00			
	$5,342.92			
Deduct—Loss on Sale of Investments	591.94			
		$4,750.98		
Accumulated Revenue, 1st January, 1934	$883.18			
Revenue for Year	296.92			
		$1,180.10		
				$ 5,931.08
Represented by—				
Investments as per Schedule No. 1		$2,997.45		
Cash in Bank		2,933.63		
			$ 5,931.08	
OSLER SCHOLARSHIP FUND:				
Capital		$12,108.90		
Accumulated Revenue, 1st January, 1934	$949.34			
Revenue for Year	619.26			
		$1,568.60		
				$13,677.50
Represented by—				
Investments as per Schedule No. 1		$11,998.60		
Cash in Bank		1,678.90		
			$13,677.50	
BLACKADER LECTURE FUND:				
Capital		$4,454.14		
Accumulated Revenue, 1st January, 1934	$587.12			
Revenue for Year	238.46			
	$825.58			
Deduct—Oration Expenses	$269.08			
		$ 556.50		
				$ 5,010.64
Represented by—				
Investments as per Schedule No. 1		$4,429.30		
Cash in Bank		581.34		
			$ 5,010.64	
BLACKADER LIBRARY OF THE HOSPITAL SERVICE DEPARTMENT:				
Balance, 1st January, 1934		$271.10		
Revenue received during year		11.89		
Donation received during year		50.00		
Profit on Sale of Investment		52.83		
		$385.82		
Less—Expenditure—Books and Literature		54.95		
				$ 330.87
Represented by—				
Cash in Bank			$ 330.87	
CANADIAN RADIOLOGICAL SOCIETY LIBRARY FUND:				
Funds transferred to C.M.A. from Estate late W. H. Dickson		$424.45		
Bank Interest		4.84		
		$429.29		
Less—Expenditure for Books		61.32		
				$ 367.97
Represented by—				
Cash in Bank			$ 367.97	
			$31,067.05	$31,067.05

SCHEDULE No. 3

SCHEDULE OF SPECIAL GRANTS AND SPECIAL GRANT FUNDS AS AT 31st DECEMBER, 1934

			Special Grant Funds	*Special Grants*
DEPARTMENT OF HOSPITAL SERVICE:				
Balance at Credit, 1st January, 1934		$ 730.24		
Grant from Sun Life Assurance Co.		11,000.00		
Bank Interest		23.85		
		$11,754.09		
Deduct—Salaries	$8,848.50			
Travelling Expenses	1,069.78			
Printing, Stationery, Literature and Office Supplies	353.51			
Postage	196.75			
General Expenses	240.91			
Depreciation of Equipment, 10%	61.86			
		$10,771.31		
Balance at Credit, 31st December, 1934				$ 982.78
Represented by—				
Cash in Bank		$426.03		
Furniture and Equipment—*Less* Depreciation		556.75		
			$ 982.78	
(Revenue, $11,023.85; Expenditure, $10,771.31; Excess Revenue for Year, $252.54.)				
DEPARTMENT OF PUBLICITY AND HEALTH EDUCATION:				
Balance at Credit, 1st January, 1934		$ 416.49		
Grant from Canadian Life Insurance Officers' Association		8,000.00		
Bank Interest		15.44		
		$8,431.93		
Deduct—Salaries	$4,870.00			
Travelling Expenses	247.80			
Postage	785.25			
General Expenses	63.16			
Stationery, Printing and Literature	177.44			
Depreciation of Furniture and Equipment, 10%	23.03			
		$6,166.68		
Balance at Credit, 31st December, 1934				$2,265.25
Represented by—				
Cash in Bank		$2,058.01		
Furniture and Equipment—*Less* Depreciation		207.24		
			$2,265.25	
(Revenue, $8,015.44; Expenditure, $6,166.68; Excess Revenue for Year, $1,848.76.)				
POST-GRADUATE DEPARTMENT:				
Balance at Credit, 1st January, 1934		$716.14		
Deduct—Depreciation of Equipment, 10%		71.61		
Balance at Credit, 31st December, 1934				$ 644.53
Represented by—				
Equipment—*Less* Depreciation			$ 644.53	
MEYERS MEMORIAL PRIZE:				
Received from National Trust Company		$100.00		
Deduct—Award made to Dr. H. C. Moorhouse		100.00		
			$3,892.56	$3,892.56

Approved.

REPORT OF THE EDITOR

Mr. Chairman and Members of Council:—

For financial reasons it has been found necessary to keep the size of the *Journal* the same as for the past two years, namely, 114 pages, on an average. This is rather less than is desirable. To meet the requirement the illustrations have had to be cut to the irreducible minimum. Nevertheless the quality of the material presented has not suffered; in fact, it is better than ever, for the reason that selection has had to be more rigid.

The number of papers submitted for publication has fallen off slightly, as compared with last year. In 1934 the number was 278, of which 38 were refused for various reasons.

Books for review are received in increasing numbers, so much so that it is impossible to consider them all. They numbered 222, of which 139 were reviewed and 83 were simply acknowledged. Many of them were distributed among the various medical libraries.

We exchanged with 75 other journals during 1934. In order to increase our range of usefulness we are sending our *Journal* free to The Science Library of the Science Museum, South Kensington, London, and to the Library of the American College of Surgeons, Chicago.

We have received valuable aid from the provincial editorial committees, whose chairmen are as follows:—

Alberta—G. E. Learmonth, Calgary;
British Columbia—D. E. H. Cleveland, Vancouver;
Manitoba—Ross Mitchell, Winnipeg;
New Brunswick—A. Stanley Kirkland, Saint John;
Ontario—J. H. Elliott, Toronto;
Prince Edward Island—J. A. McPhee, Summerside;
Saskatchewan—Lillian A. Chase, Regina.

An attempt was made this year to report more adequately the proceedings at the Annual Meeting. That this was possible was due to the kind cooperation of Dr. Grant Fleming, the Publicity Manager, who furnished the *Journal* with short abstracts of many of the papers contributed. It should be pointed out that the papers read at the Annual Meeting are, *ipso facto*, the property of the Canadian Medical Association and should be handed in to the General Secretary at the time of the meeting, with a view to publication in the Association's *Journal*. It may not be possible to publish them all, but it is possible to notice those not published in full if the authors would furnish the General Secretary with short summaries. This is an idea which is carried out by the American Medical Association and one which we in Canada could adopt with advantage. If the summaries could be in the hands of the General Secretary one month before the meeting, publication would be facilitated. The report of the Annual Meeting would also be enhanced in value if secretaries of Sections would furnish the Editor through the General Secretary with short notes of the proceedings of their Sections.

Under "Association Notes" opportunity was taken to give some account of the activities of the Section of Military Medicine since its inception in 1931.

In accordance with the policy approved of a year ago by the Executive Committee, namely, to endeavour to keep the general membership posted in regard to the business of the Association as conducted between Annual Meetings a generous amount of space has been given to the proceedings of that Committee, in particular at their meeting on October 30, 1934. The reports of the Study Committee on Cancer, of the Committee on Specialists, and of the Committee on Maternal Welfare have been published in full, and also the important matter of the unification of the Canadian Medical Association has been dealt with, these topics being also discussed editorially.

Perhaps attention should be directed to the Supplement which appeared in the September issue. It was very lengthy this time, totalling 64½ pages, as compared with the usual 25. The enlargement was due to the voluminous report of the Committee on Medical Economics. It was thought desirable on this account to provide a Table of Contents for the whole Supplement, as also a separate one for the Report on Medical Economics.

The series of articles on "The Early Diagnosis of Cancer," begun last year, has come to an end. We hope they have proved helpful. "Notes on the British Pharmacopœia and the Canadian Formulary," kindly prepared by Drs. V. E. Henderson and G. H. W. Lucas, of Toronto, have also been concluded. This series was of great practical value.

With a brief intermission, the Section of Medical Economics was re-commenced. The Medico-legal Section, which for a time had also been discontinued owing to the difficulty of obtaining accurate information has been resurrected, the court cases dealt with being taken from the official records and commented on by a lawyer. This procedure should make this Section of greater value to the profession than heretofore.

The Section of Abstracts now covers the whole field of medicine, and some new abstractors have been secured. It is hoped that in time this Section will be improved by the inclusion of a wider range of journals.

A novel feature, intended to replace the usual Editor's New Year's Greetings to the Membership, was a Message from the President, which was featured in the January number. Doctor McEachern took the opportunity to refer to several important topics that have been engaging the attention of the Association, such as, Cancer Control, A National Department of Health, Social and Medical Legislation, the Control of Specialism, Membership and Cooperation between our various medical organizations, and the Need for Unity in our Association. With the February number came the announcement of the inauguration of the King George the Fifth Silver Jubilee Cancer Fund for Canada, which was featured in the form of letters from the President, from Dr. Alexander Primrose, Chairman of the Cancer Study Committee, and from the Editor.

It has been the custom for the *Journal* to publish each month, among the preliminary matter, a list of the Officers of the Association and of the Members of the Council and of the Exectuive. Beginning with the February number a suggestion was put into operation that we publish the names of the various Sections of the Association, the Standing Committees, and the Provincial Medical Associations, together with the names of their presidents and secretaries. This practice will be continued in alternate months.

We began publicity in connection with the joint meeting of the Canadian and American Medical Associations, taking place in Atlantic City, by publishing last December some general information and a list of the various Sections and their Canadian officers. The May issue was the Convention Number, and it contains a very full account of the place of meeting, with the proposed program.

The Editor was asked to call attention to several special topics dealt with at the Annual Meeting held in Calgary. One of these was the part played by the bondholders in saving the Association in 1921. An editorial comment appeared in due course dealing fairly fully with the situation as it existed at that time and the measures that were taken to meet it. The second was the good record of the medical profession in Canada in regard to addiction to narcotics. This was dealt with in a short review of the narcotics situation. The third was maternal welfare. A valuable paper by Dr. W. B. Hendry, presented to the Ontario Medical Association last June, a reprint of the Report of the Committee on

Maternal Welfare, and an abstract of Doctor Hendry's address before the "Mothers' Day Conference" at Toronto on the same subject were published in the November issue, together with editorial comment. Certain other important topics have also been dealt with editorially. Among them may be mentioned Immunization in Staphylococcus Infection; Silicosis; Marijuana; Medical Economics; The Action of Therapeutic Agents; Histamine in Treatment; The Nursing Profession; Weather, Health and Hospitals; The Hospital Situation in Canada; Strychnine Poisoning in Children; The Cancer Campaign; Carcinogenic Substances; The Use and Abuse of Codeine in Canada; and Unity in the Association—a wide list of subjects.

It is impossible for lack of space to even mention the titles of all of the many admirable articles that have been published during the year. Without intending to make invidious distinctions, some few may be listed. They are the Presidential Address, by Dr. J. S. McEachern; the Second Blackader Lecture on "Some Aspects of Virus Infection," by Dr. James Craigie; "Staphylococcus Antitoxic Serum," by Dr. C. E. Dolman; a series of articles on "Silicosis," by Drs. Franks, Dolan, Irwin, Robson and King; which were illustrated by a number of illuminating pictures the like of which had never appeared before in a medical journal; "Xanthomatosis," by Dr. Samuel Reich; "Histological Variations in Animal Thyroids in Western Canada," by Drs. A. C. Abbott and J. Prendergast; "Cryptomyces pleomorpha," by Dr. O. C. Gruner; a number of papers on various anæsthetics, by Drs. H. R. Griffith, Wesley Bourne, P. E. O'Shaughnessy, B. B. Raginsky, and K. M. Heard; on various aspects of the vitamin treatment of rickets, by Drs. Drake, Tisdall and Brown; on phosphatase, by Drs. King and Armstrong; on the development of tar carcinoma in mice, by Dr. J. R. Davidson; "On the Importance of Bedside Study and Teaching," an Osler Address, by Dr. T. B. Futcher, of Baltimore.

New appliances were described, as follows:— An Improved Pneumothorax Apparatus, by Drs. W. H. Hatfield and W. K. Tremble; A Simple Upright Casette Holder, by Dr. J. H. Wesley; An Improved Wound Support and Dressing, by Dr. O. DeMuth.

Books by Canadian authors reviewed were:— "The Essentials of Infant Feeding and Pædiatric Practice," by Dr. H. P. Wright; "Sterilization? Birth Control?" by Dr. Helen MacMurchy; "A Textbook of Pathology," by Prof. William Boyd; "Constructive Eugenics and Rational Marriage," by Dr. M. Siegel; "Our Heritage and Other Addresses," by Hon. Dr. H. A. Bruce; "All in the Day's Work," by Dr. Abraham Groves; "Internal Parasites of Domestic Animals," by Prof. T. W. M. Cameron.

The eight-hundredth anniversary of the birth of Maimonides, the great mediæval Jewish physician, fell on March 30th of this year, and the *Journal* recognized the event by publishing an article in the April issue in "Men and Books" on Maimonides from the pen of Dr. A. B. Illievitz.

Our thanks are due to Drs. E. M. Eberts, J. A. McClelland, Harris McPhedran, and Egerton L. Pope for the contribution of special articles at our request; to Professors E. G. D. Murray and D. L. Thomson for editorials on technical subjects; to Dr. J. J. Heagerty, for information relative to the Food and Drugs Act; and to Col. C. H. L. Sharman, for facts about marijuana and codeine; to the chairmen of the provincial editorial committees; finally, to Dr. H. E. MacDermot, the Assistant Editor, to the office staff, and to the Murray Printing Company for their ready and efficient assistance.

All of which is respectfully submitted.

A. G. NICHOLLS,
Editor.

Approved.

REPORT OF THE MANAGING EDITOR

Mr. Chairman and Members of Council:—

The expenses of the *Journal* have been maintained within the budget allowance and on the same scale as the previous year. It is gratifying to report that receipts from advertising increased during the year. In 1933 receipts were, $25,237.55, in 1934, $26,766.49. This reflects in some way the improvement in the quality of the *Journal* and indicates the increasing esteem in which it is held by advertisers.

The following is a comparative table of general conditions over the past four years:—

	1931	1932	1933	1934
Original Articles, Case Reports, Retrospects, Men and Books, Clinical and Laboratory Notes	267	258	271	278
Number of Pages—				
Text	1,614	1,424	1,376	1,361
Advertising	715	704	649	697
Illustrations	363	235	203	151

JOURNAL COVERS

Commencing with our January issue the cover of the *Journal* was changed from a soft dull to a glossy surface stock. This change was made for the purpose of accommodating advertisers, the old stock having proved unsuitable for use of illustrations. Although the new stock is not entirely satisfactory no further change is anticipated at present.

All of which is respectfully submitted.

F. S. PATCH,
Managing Editor.

Approved.

REPORT OF THE COMMITTEE ON CREDENTIALS AND ETHICS

Mr. Chairman and Members of Council:—

As Chairman of the Committee on Credentials and Ethics, I have to state that this Committee has transacted no business this year, nothing being submitted to it for consideration.

All of which is respectfully submitted.

J. D. ADAMSON,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON PHARMACY

Mr. Chairman and Members of Council:—

The proposals made by the Canadian Pharmaceutical Association in 1934 for amendments to the Patent or Proprietary Medicines Act were not dealt with by the Government last year, and similar though slightly differing amendments were recently sent to the Canadian Medical Association for their approval.

The Chairman of the Committee on Pharmacy was consulted in regard to these and in view of the correspondence held with the members of the Committee last year, and statements made in the report of the Committee last year, he recommended that the Canadian Medical Association should approve of these amendments. The first of these required that any proprietary or

patent medicine for internal use containing a drug contained in the Schedule to the Act, should be made under the control of a registered pharmacist. Secondly, that any proprietary containing any of the drugs listed in the Schedule to the Act should be sold only through a licensed druggist. Thirdly that the word "poison" should be placed on the label of the bottle containing any of the drugs which would be placed in a new division of the Schedule and which would contain active poisons such as Arsenic, Belladonna or Strychnine; and a fourth amendment prohibiting the door to door peddling of patent or proprietary medicines.

The Manitoba Medical Association adopted a resolution which was referred to the Chairman for consideration, as was also a resolution adopted by the College of Physicians and Surgeons of Manitoba. The action of these bodies is intended to produce a closer supervision of the registration of proprietary medicines and their sale. A quotation from the letter of the Registrar of the College puts this matter in a concrete fashion.

> "The opinion of the meeting was that a Joint Campaign, with representatives from the Canadian Medical Association, the Dominion Drug Association and the College of Physicians and Surgeons of each Province, should endeavour to urge the authorities at Ottawa to issue no patents on either medicines or apparatuses for treatment of diseases, except such as may be sanctioned by an Advisory Committee from these various Associations, and the following motion was passed:
>
> 'That the Council of the College of Physicians and Surgeons of Manitoba recommend a Committee on pharmaceuticals and apparatuses'."

In the opinion of the Chairman of the Committee on Pharmacy it would be highly advisable for the Government to set up an Advisory Medical Committee to deal with matters arising out of both licensed and non-licensed proprietary medicines. This Committee should be of a statutory character, appointed by the Department of Health on the nomination of certain medical and possibly pharmaceutical organizations (Canadian Medical Association and Canadian Pharmaceutical Association). It is impossible for the officials of the Department of Health to be as closely in touch with the general effect to be produced by the registration of proprietary medicines or the effect of interpretations of the Food and Drugs Act and the Patent or Proprietary Medicines Act on the practise of medicine in the country as representatives of these Associations would be. In order to obtain the best for the public health an active cooperation between the medical and pharmaceutical professions and the Department of Health is essential.

It is recommended that these matters be considered by the meeting of the Council.

All of which is respectfully submitted.

VELYIEN E. HENDERSON,
Chairman.

Approved.

In discussing this report attention was called to certain so-called therapeutic apparatus such as the "auto-electronic radioclast", which is being widely advertised at the present time, and the opinion was expressed that steps should be taken to control such apparatus in the same way as patent medicines are controlled. The following resolution was passed:—

"That Council instruct the Committee on Pharmacy to consult with all the authorities interested, including the Committee on Legislation of this Association, with regard to the whole question of drugs and apparatus, and present to the Executive Committee before the next annual meeting what they consider would be an ideal arrangement for the year 1936."

BARBITURATES

The following resolution from the Academy of Medicine, Toronto, was brought to the attention of Council:—

"WHEREAS it has been reported to the Section of Preventive Medicine and Hygiene that many cases of poisoning from barbiturates in over-doses, and also of skin affections arising in persons who have taken medicinal doses for a prolonged time, have occurred during the past year; and

WHEREAS insidious types of poisoning are now also known to occur in persons taking amidopyrine and cinchophen for prolonged periods; and

WHEREAS all these poisons and many others do not appear on the poison schedule of the Province of Ontario but can be bought freely in the drug stores to the detriment of the public health;

BE IT RESOLVED THAT this Section suggests to the Council of the Academy that it pass the following resolution and forward the same to the Minister of Health of Ontario and to the College of Pharmacy and to the Secretary of the Ontario Medical Association,—

That an amendment be introduced into the Pharmacy Act to set up a schedule of drugs other than that now existing for poisons, and that this new schedule contain such drugs as in the interest of the public health should be sold only on a prescription of a registered physician."

After considering this resolution, it was duly moved, seconded and agreed by Council—

"That the Association put itself on record as being in favour of barbiturates being sold only on doctors' prescriptions; and that this recommendation be forwarded to the Committee on Pharmacy as an expression of opinion of this Executive Committee, with the request that the Committee on Pharmacy report to the Executive Committee regarding the whole situation in connection with barbiturates."

REPORT OF THE STUDY COMMITTEE ON NURSING OF THE C.M.A. AND C.N.A.

Mr. Chairman and Members of Council:—

In 1927, the Joint Study Committee on nursing education in Canada was organized by the efforts of the Canadian Nurses' Association and the Canadian Medical Association. This committee was brought into being to study nursing education and nursing conditions in Canada and to offer such suggestions as might be helpful in improving the nursing situation. As Council is aware, this work was completed, the report issued and the findings of the report are the subjects of study by joint Committees in the nine Provinces of Canada.

The members of the Joint Study Committee are of the opinion that they have carried to completion the work for which they were originally organized. It has been intimated to us however that there are other problems which the nursing profession desires us to consider. As we have no authority to go beyond the special work originally assigned to us, instructions would have to be secured from the two associations if new activities are to be undertaken.

The executive of the Canadian Nurses' Association at their meeting in Regina on March 23, 1935, passed a resolution proposing, in so far as they were concerned, that the activities of the National Joint Study Committee include any matter of mutual interest which might be referred by either association.

In view of this action by the Executive of the Canadian Nurses' Association it is necessary if the committee is to be continued for the Council of the Canadian Medical Association to give its sanction to an extension of the activities of the committee to include those subjects of mutual interest. Your committee would recommend to Council that it be continued.

All of which is respectfully submitted.

G. STEWART CAMERON,
Chairman.

Approved.

REPORT OF THE STUDY COMMITTEE ON CANCER

Mr. Chairman and Members of Council:—

The Committee has met on many occasions and the Minutes of these meetings are available for members of the Council.

At a meeting of the Executive Committee held in Ottawa on October 30, 1934, a report of the study committee on cancer was presented. After full discussion the Executive Committee authorized the establishment of "A department of Cancer control in the Canadian Medical Association."

The study committee on cancer, after careful consideration at various meetings, drew up a comprehensive program suggesting the various activities that would legitimately be undertaken by such a department. The annual expenditure of a large amount of money would be necessary to carry out this program. As funds were not available, and as it seemed a difficult, if not impossible task to secure the necessary capital sum at this time of economic depression, the committee reluctantly determined to relinquish the idea of putting this scheme into operation at once. It was agreed that in the meantime the various activities at present in operation in the Canadian Medical Association should be utilized to the limit of their resources to carry out the details of our program, including Divisions of Post-Graduate Education, Publicity and Health Education, Hospital Service and the *Journal*.

In January, 1935, I was informed that His Excellency The Governor-General of Canada, had determined to open a fund, for the relief of cancer, to be known as "The King George Fifth Silver Jubilee Cancer Fund for Canada", and, as chairman of the study committee on cancer of the Canadian Medical Association, I was nominated as one of the seven trustees of the fund.

The establishment of the Silver Jubilee Fund put an entirely new complexion on the whole project and in my report to the Executive Committee that met in Toronto on April 6, 1935, I suggested that the decisions of the Cancer Study Committee "may be radically revised as the result of the prospect of securing adequate funds for activities in connection with cancer."

After the consideration of my report the Executive Committee on April 6, 1935, adopted the following resolution:—

Moved by Dr. Meakins,
Seconded by Dr. FitzGerald,

"That the resolution passed by the Executive Committee on October 30th, be still considered the confession of faith of the Canadian Medical Association and that the resolution be passed to the committee on cancer for their information."

In this resolution the Executive Committee have reaffirmed their action of October, 1934, and as a result the Study Committee on Cancer is now actively engaged in formulating a comprehensive program. It is hoped that adequate financial assistance to make the program effective may be obtained from the King George Fifth Silver Jubilee Cancer Fund for Canada.

All of which is respectfully submitted.

A. PRIMROSE,
Chairman.

Approved.

In presenting this report, Dr. Primrose called attention to the following recommendations made by the Study Committee on Cancer:—

1. The personnel of the Committee should be enlarged to include the Chairmen of the Provincial Cancer Committees.

2. All requests for funds either from individuals or institutions should first be submitted to the Provincial Cancer Committee and transmitted by them to the Study Committee on Cancer of the C.M.A.

3. In the opinion of the Study Committee on Cancer, before any money is allocated by the Board of Trustees of the King George V. Silver Jubilee Cancer Fund for Canada, a survey should be made of the whole of Canada to bring the cancer problem into full view.

4. In the opinion of the Committee, it would be best to spread the capital sum with interest over a period of say ten years.

In the discussion with regard to this matter attention was called to the following recommendations forwarded to the Board of Trustees of the King George V. Silver Jubilee Cancer Fund for Canada by the Dominion Council of Health meeting in Ottawa on June 6th:—

1. That the necessary steps be taken to insure that the medical profession is kept continuously informed as to the latest developments in regard to early diagnosis and the most effective methods of treatment for cancer.

2. That the necessary action be taken through the medium of official health agencies to provide a soundly based, carefully planned and continuous program, having as its object the instruction of the public in regard to the nature of the disease, its earliest manifestations, and the necessity for prompt and efficient treatment.

3. That in view of the moderate amount of money available from the fund, we are of the opinion that no allotment should be made for any new research activities.

It was the feeling of those present that any recommendations which should be made to the Board of Trustees with regard to the cooperation of the Canadian Medical Association in the fight against cancer should be left to the discretion of Dr. Primrose who is fully aware of our ability to perform such services as may be entrusted to us.

REPORT OF THE COMMITTEE ON INTER-PROVINCIAL RELATIONS

Mr. Chairman and Members of Council:—

As Chairman of the Committee on Inter-provincial Relations I beg to report that during the past year I have not received any communication of any description from the different provinces, so I assume that the relations between the different provinces must be working in harmony, and I therefore did not find it necessary to call a meeting of my Committee during the past year.

All of which is respectfully submitted.

G. A. B. ADDY,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON MATERNAL WELFARE

Mr. Chairman and Members of Council:—

I have the honour to present the annual report of the Maternal Welfare Committee for the year 1934-1935.

The vital statistics for the first nine months of 1934 show 878 maternal deaths from all cases with a mortality rate of 5.22 per thousand live births.

During that period there were 127 deaths from the toxæmias of pregnancy, 72 deaths from hæmorrhage and 188 deaths from puerperal infection.

These figures show that there has been little or no improvement in the mortality rate during the last four years.

Deaths from the toxæmias are chiefly due to the absence of prenatal care or to lack of attention paid to the danger signs of pregnancy. Deaths from hæmorrhage are mainly due to accident, faulty diagnosis or imperfect technique in delivery. Deaths from infection are almost entirely due to the introduction of infection from without.

Your committee is therefore, of the opinion that a campaign of education of both the public and the profession should be undertaken and would recommend

1. That a sub-department of maternal welfare be re-established under the control of the Federal Minister of Health.
2. That a publicity campaign be instituted by this department for the education of expectant mothers and fathers and the public generally.
3. That provincial, district and local medical societies be urged to devote at least one meeting a year to maternal welfare.
4. That all Municipal Medical Officers of Health be invited to ask the cooperation of the social agencies, welfare organizations, nursing orders and physicians in their district for the purpose of putting into effect a scheme of maternal welfare, the object of which shall be to provide adequate prenatal, intranatal and postnatal care for their citizens and to carry out such a program of education as is considered advisable for their district.

The committee wishes to take this opportunity of commending the excellent work of Dr. A. R. Dafoe of Callander in connection with the Dionne quintuplets.

All of which is respectfully submitted.

W. B. HENDRY,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON LEGISLATION

Mr. Chairman and Members of Council:—

The Committee on Legislation met at Ottawa with a large attendance and reviewed generally matters of legislative interest. There were no requests requiring action placed before this committee either by your executive or the individual members of the profession. Neither has there been any legislation introduced during the year requiring the attention of your Committee.

All of which is respectfully submitted.

G. D. STANLEY,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON THE ROYAL COLLEGE OF SURGEONS

Mr. Chairman and Members of Council:—

It is of great interest to note that the Canadian Medical Association a few years ago succeeded in persuading the Royal College of Surgeons of England to hold the primary examination for the Fellowship in Canada. This was the first time that the Royal College in England held any of its examinations out of London.

Although there have been no recent examinations in Canada, it is worthy of remark that the privileges obtained from the Royal College by this Association, have been requested by other parts of the Empire, notably in Australia where a large number of candidates are appearing for the primary examinations during this present year.

Thus a system initiated through the Canadian Medical Association has been adopted for other parts of the British Empire.

In the meantime your Committee has no activities to report but its services may still be required in the event of candidates for the primary examination desiring to present themselves in Canada.

All of which is respectfully submitted.

A. PRIMROSE,
Chairman.

Approved.

REPORT OF THE MEYERS MEMORIAL COMMITTEE

Mr. Chairman and Members of Council:—

It is the opinion of the Meyers Memorial Committee that the original purpose of the founder of the Memorial is gradually receiving more attention, not perhaps from the general body of the profession but from the increasing numbers whose professional life is spent in public institutions of the various provincial governments.

The only recommendation the Committee has to make is that the Association continue to give as wide publicity as possible to this bequest, first, through the columns of the *Journal*; second, by soliciting the cooperation of the Canadian National Committee for Mental Hygiene; and third, by circulating to the Mental Hospitals of Canada information as to the conditions governing the prize.

All of which is respectfully submitted.

J. T. FOTHERINGHAM,
Chairman.

Approved.

REPORT OF THE OSLER MEMORIAL COMMITTEE

Mr. Chairman and Members of Council:—

Your Committee begs to report that it has held one meeting during the year, attended by the nucleus resident in Montreal.

A very successful Osler Day was held at Hamilton on February 27th. Dr. J. Heurner Mullin, a member of this Committee, took an active part in the arrangements. The proceedings have been fully recorded in the April issue of the Association *Journal*. Your Committee hopes that similar pilgrimages to the one undertaken at the Hamilton celebration will be organized to scenes of Osler activities in Toronto, Montreal, Philadelphia, Baltimore, and, possibly, even to Oxford.

Your Committee is pleased to know that Dr. Lewellys F. Barker of Baltimore has been selected to give the Osler Oration at the Atlantic City meeting this year.

All of which is respectfully submitted.

C. P. HOWARD,
Chairman.

Approved.

In connection with this report, it was stated that the Academy of Medicine, Toronto, is planning to hold an Osler Day Celebration in Toronto in 1937.

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION

Mr. Chairman and Members of Council:—

The acceptance of the new point of view with regard to the medical curriculum, namely, that from its beginning and throughout the course attention should be directed primarily to health, its cultivation and preservation, means that the preclinical courses in anatomy, physiology and biochemistry must be revamped.

In addition to teaching them in the present way as scientific subjects in which their application will be taught later in the clinical years on patients in the hospital, they should be taught also with the object of providing the student with a knowledge (*a*) of the structures of the human body with the characteristic features which indicate that they are healthy in size, form and relationship; (*b*) of the functions of the living person who is in a state of health; (*c*) of the methods of examination of a person that should be carried out with the object of determining whether a state of health exists or not.

As the state of health depends upon the mental condition of the individual in addition to the physical, the student should be given instruction on the mental functions, emotions and personality of the human being. He should have the opportunity of getting "some practical and theoretical experience in personality study, personality function and personality management" (Adolf Meyer). Courses with this aim in view have already been established in some colleges under the name of psychology, psychobiology or physiology of the mind.

The result of such courses will be that the practitioner of the future will be infinitely better equipped to study the personalities of his patients than those of the present generation who received no such training and consequently had to approach the investigation of their patients without any preconceived ideas on this important aspect of their health.

In this newer trend of medical education, greater recognition is being given to the importance not only of the disease which the patient has but of the patient who has the disease, his reactions as an individual, his environment, and his hereditary background. The old adage "Examine the whole of your patient" is assuming greater significance. It will be by a combined attack on the physical and psychological side that medicine in the future will advance and still further aid human suffering.

From the standpoint of the subject of therapeutics, it has become evident that greater attention should be given to the teaching of the physical methods of treatment during the undergraduate course. The graduate should be capable of recognizing the indications for the different types of physical therapy, the occasions on which they should be used, and their modes of action, so that he can order them with discrimination, in an intelligent manner, and with full knowledge of their defects and limitations. Massage, exercises, manipulative surgery, electro-therapy including diathermy, hydrotherapy and occupational therapy should all be included in the course on this aspect of therapeutics.

The Committee begs to recommend that the Canadian Medical Association give their endorsation to the principle of The Medical Council of Canada assuming the responsibility (*a*) for establishing and appointing Boards of Examiners at various centres in Canada for the purpose of conducting examinations in each of the Specialties, (*b*) for the granting of certificates of qualification to Specialists and (*c*) for the publication of a Register of qualified Specialists in Canada, as proposed in the Report of the Committee on Specialists.

All of which is respectfully submitted.

E. STANLEY RYERSON,
Chairman.

Approved.

REPORT OF THE COMMITTEE ON ECONOMICS

Mr. Chairman and Members of Council:—

The Committee on Economics presented to the Annual Meeting of 1934 a report on A Plan for Health Insurance in Canada. This report was received by Council and passed to the provincial associations, a copy being sent to every doctor in Canada with the request that they express their opinion regarding it. From the provincial replies, the following statements are quoted:—

British Columbia

No report to date.

Alberta

No report to date.

Saskatchewan

"Copies of this report were sent to all our members, either through the *Journal* or by the special copies of the report which we received. On December 12, 1934, our Directors passed the following resolution: 'That Dr. S. E. Moore be a Committee to continue his investigations *re* Health Insurance'. Since Dr. Moore was requested to continue his study there has not been any meeting of the Directors, and further, the Association has not taken any action in the matter."

Manitoba

"That the Committee on Sociology, having considered the report of the Committee on Economics of the Canadian Medical Association, beg to recommend to the Executive of the Manitoba Medical Association the adoption of the general principles of the report, and further wish to recommend that, in any system of

health insurance evolved for the Province of Manitoba, all residents of rural Manitoba should come under the scope of the plan, but that, for residents of urban centres, the question of an income level at which the compulsory features of the scheme would become non-operative should receive further consideration; and that, in the administration of any plan, the control should be under a representative Commission, which should be linked up with the Provincial Department of Health and Public Welfare.''

Ontario

No report to date.

Quebec

''The report prepared by the Committee on Social Insurance of the Province of Quebec Medical Association is much the same, as regards the plan submitted, as the report of the Committee on Economics. As you know, our report did not receive the approval of the members of the Association, at one of our general meetings . . . . The Province of Quebec Medical Association is not pushing forward any form of Health Insurance for the present time, but it stands ready to work with the government and contribute its part in providing for the medical profession the best possible agreement, if such government decides on the establishment of Health Insurance.''

New Brunswick

''That, at present, we have no suggestion to offer as to the modification of the report as the report submitted is so indefinite and incomplete that it is impossible to arrive at any definite opinion concerning it.''

Nova Scotia

No report to date.

Prince Edward Island

''They wished to compliment the Committee on the very comprehensive and excellent plan for Health Insurance as submitted.

''They appreciate the value of such a plan for future, if not for present, application.

''They approve of the general outline of this plan, but do not consider it applicable to conditions as they exist in Prince Edward Island at the present time.''

During the course of the past year, Alberta has shown a desire to proceed with its plan for Health Insurance, trying it out in two areas, the one urban and the other rural. The government of British Columbia has drafted legislation which is to be printed and distributed in order that the points may be freely discussed by all concerned, so that the draft Act may be modified, before its introduction at the next session of the provincial legislature, in the light of such free discussion. Manitoba desires to experiment in one area of the province.

Acceptance of the principle of state responsibility for the medical care of the unemployed has been seen in some parts of most of the provinces. Ontario is the only province where the principle has been accepted on a province-wide basis by the provincial government. Here it is most interesting to note that the arrangements for the provision of medical care for the unemployed are made by the Government through the Ontario Medical Association, which Association assumes responsibility for the payment of physicians, the maintenance of standards of medical care, et cetera.

The Act presented to and passed by the Dominion Parliament on Social Insurance includes a Part IV, National Health. This part provides that the Commission which is to be set up is to study the provision of medical care on a cooperative basis by means of insurance or otherwise, and to submit a proposal for Dominion cooperation in providing such medical care.

It would appear that the time is not far distant when the Canadian Medical Association will be asked to express the views of the medical profession of Canada on this subject of Health Insurance. The Committee on Economics would therefore suggest that due consideration be given to the endorsation, modification or rejection of the principles laid down in its report, so that the Canadian Medical Association may be prepared, if called upon, to voice an opinion which will be the accepted opinion of the medical profession of Canada.

All of which is respectfully submitted.

W. HARVEY SMITH, *Chairman.*
GRANT FLEMING, *Secretary.*

Approved.

Following the presentation of this report, Dr. Fleming called attention to the following resolution which was passed by the Ontario Medical Association at its annual meeting in Fort William in May, 1935:—

"WHEREAS the medical profession of Ontario through a questionnaire have accepted overwhelmingly the principle of health insurance, and have favoured the promulgation and promotion of a plan for Ontario; and

WHEREAS any plan of health insurance should be national in scope; and

WHEREAS a united professional opinion is accessory thereto; and

WHEREAS certain conclusions of the C.M.A. Committee on Economics might be modified to advantage;

THEREFORE BE IT RESOLVED that this Association recommend to the Council of the Canadian Medical Association that the Report of the Committee on Economics be referred back for further study in the light of the report of the O.M.A. Committee on Inter-Relations, and that the following principles be incorporated in a revised C.M.A. Plan for health insurance in Canada:—

1. That provincial administration be by an independent non-political commission, representative of the groups concerned, and having full responsibility for the operation of the scheme and appointment of the personnel.
2. That local or regional advisory professional committees be similarly constituted.
3. That each 'family head' carry an equal burden of the cost, regardless of the number of dependents.
4. That indigents be classified and premiums levied on a sliding scale according to income and the number of dependents.
5. That in addition to hourly nursing continuous nursing service be available when necessary in the home.
6. That the method of remuneration, so far as possible, be uniform.
7. That no economic barrier be imposed between doctor and patient, with regard to any of the benefits."

In the discussion which ensued, the following opinions were expressed:—

The Chairman—"Are we prepared to express an opinion on behalf of the Canadian Medical Association in view of the fact that none of the provinces have sent in an unqualified approval of the principle of health insurance?"

A Member—"I do not know whether we can make a decision on this matter at the present

time. After the publication of this report and its distribution in the Province of Quebec, I received a number of letters which are absolutely contradictory to one another. For instance, in one village, one doctor is calling for some plan of health insurance and another doctor in the same place is absolutely opposed to it. I do not think the C.M.A. as an Association should take a step at the present time. The opinions are diversified, some for and some against. My opinion is that the C.M.A. is not ready at the present time to express an opinion if at least one province is not in favour of it."

A Member—"The Committee on Inter-Relations of the Ontario Medical Association gave a very complete report at the Fort William meeting. A careful study was made of the C.M.A. Report of the Committee on Economics and, in the principles drawn up by the Ontario Committee they parallel those of the C.M.A. Committee, agreeing in some cases and in some cases suggesting certain revisions. The principles of the Ontario Committee were unanimously adopted at the annual meeting. In light of the fact that the Ontario Medical Association has unanimously accepted the principles of the Committee on Economics I should think that those suggestions should be very carefully considered by our Committee on Economics before final action is taken."

The Chairman—"I would like to have an expression of opinion from members of Council on whether or not they would consider health insurance a good thing for the community."

A Member—"Those of us who are dealing with the subject from the standpoint of health alone are extremely interested in health insurance because it will help to reach a larger number of people than we can reach today. In the case of tuberculosis it would mean earlier diagnosis, quicker isolation, and earlier cure. We accept the principle that has been laid down by the Ontario Medical Association that public health should be the basic principle of health insurance. I do not see how we could separate the two. As far as the doctor is concerned, as public health advances, the work of the doctor decreases. There will come a day in fifteen or twenty-five years when the general practitioner is going to have a very hard time to live. There is the question of whether or not the profession is going to be regimented. The total cost of illness in Canada is $240,000,000 a year. The number of days' illness averages about eight and the average cost about $3.00 a day. I doubt if there is sufficient money to pay the doctors on a fee basis. Every scheme which has been proposed suggests cutting down the doctors' fees. On a capitation basis, it would give the general practitioner many advantages."

A Member—"I take it that we are considering this subject from the point of view of the public. The first question that is to be answered is whether the public under a scheme of health insurance would be better off than they are under the scheme in operation today. I was interested in the point of view of the last speaker that it would be of value from a public health standpoint in the reduction of communicable diseases such as tuberculosis, diphtheria, etc. If these diseases were now on the increase rather than on the decrease the argument would be stronger. There is another argument with regard to introducing periodic health examinations. Very many people are subjected to periodic health examinations and do not get a complete examination. One of the crying needs is the education of ourselves as to our moral responsibility to make our examination complete."

A Member—"I am of the opinion that health insurance would be a benefit to the public largely. I differ from a former speaker who expressed doubt as to whether there is money enough to supply medical services on a fee basis. I think the only satisfactory system of health insurance would be on the fee basis. The physician should be paid for the amount of work he does on a fee basis and the amount of work he does and the kind of work he does should be controlled by organized medicine. A good system of health insurance, under medical control, can be given at moderate cost."

A Member—"I do not think there is anyone in this room who feels that the study that has been made by the C.M.A. has been an infringement of the rights of the C.M.A. We are not trying to force health insurance upon anyone against his will. In my opinion, we do not wish to do anything which would appear to be the forcing of a health insurance plan. We must take some action. We have a motion that we adopt this report. Could we not adopt the report in this way; if and when any scheme of health insurance is initiated it is the opinion of this Council that the principles to guide the formation of a plan as laid down in this report are endorsed by the C.M.A."

A Member—"The Association should go on record as expressing approval of the principles as a guide. Exact interpretation will have to vary from place to place. Cash benefits should not be included in health insurance."

A Member—"The best interests of the profession would be served if the Canadian Medical Association had a definite representative in each province, so that if representations are to be made by any government they can be made with the endorsation of the C.M.A."

"The question of cash relief is one of the greatest difficulties in the British scheme."

A Member—"Alberta is the only province of the Dominion that has so far enacted legislation with regard to health insurance. Within the next three weeks a Commission will be appointed to put into force the legislation already passed. We have been working on this problem for the last five or six years, knowing that it was sure to come up. We have made a very intensive study of all phases of the problem. In this we secured a great deal of help from the C.M.A. with regard to principles. We adopted four or five which are quite contrary to those in British Columbia. We have opposed the idea of cash benefits. We want free choice of doctor and payment for services rendered. Unfortunately, already the Government is considering the appointment of a joint committee to study a schedule of fees. I would suggest that the Committee on Economics carry on this work and that nothing definite be done by the C.M.A. at the present time."

Attention was called to the conference of Ministers of Health in Ottawa last May when the problem of health insurance came up for consideration. The Minister of Health for British Columbia is hoping that something will be attempted which will make it possible for him to correlate the proposed Bill in British Columbia with some National Plan. The Minister of Health for Alberta expressed the hope that the Government of Canada would take a national view of this problem and assist the provincial ministers in following through with regard to health insurance. In Ontario the Minister of Public Welfare has handed over to the medical profession of that Province the administration of medical relief, and he is going to England this summer to study health insurance very intensively. This question should be considered without political complication. It was suggested that, before health insurance is enacted in any part of Canada, a survey should be made of every part of Canada.

The following resolutions were then duly moved, seconded, and carried:—

1. THAT in the event of health insurance being initiated by any authority, in any section or area of Canada, the Canadian Medical Association endorse the principles governing a health insurance plan as laid down in the Report of the Committee on Economics as presented at the annual meeting in Calgary in June, 1934.
2. WHEREAS, it has been brought to the attention of this Council that the Ministers of Health of Canada, meeting in Ottawa, proposed that a Royal Commission be appointed to make a survey of Canada in respect to the health services of Canada;

   BE IT RESOLVED by this Council that we heartily approve of such a survey being made, and that the Commission be given the widest possible powers; and, furthermore, we respectfully submit that before any scheme of health insurance be enacted in any part of Canada it would be the part of wisdom to see that such a survey has previously been made.
3. THAT a copy of the above resolutions be sent to the Provincial Medical Associations for their information, with a covering letter stating that, while the C.M.A. has neither the desire nor the authority at this time to make any pronouncement for or against health insurance, Council feels that the above-mentioned resolutions would be of definite value to any part of Canada as indicating the opinion of Council with regard to the principles underlying any possible plan of health insurance.
4. THAT the General Secretary be instructed to send a copy of the second resolution, as quoted above, to the Honourable Minister of Health for Canada and to the Ministers of Health for the nine provinces.

REPORT OF THE COMMITTEE ON GROUP HOSPITALIZATION

COMMITTEE ON GROUP HOSPITALIZATION

Corresponding Members:

G. A. B. Addy	Saint John, N.B.
Geo. F. Stephens	Winnipeg, Man.
A. F. Anderson	Edmonton, Alta.
W. B. Burnett	Vancouver, B.C.
A. Grant Fleming	Montreal, Que.

Nucleus Members:

G. S. Cameron	Peterborough, Ont.
J. K. McGregor	Hamilton, Ont.
H. K. Detweiler	Toronto, Ont.
Dennis Jordan	Toronto, Ont.
A. J. Mackenzie	Toronto, Ont.
S. J. N. Magwood	Toronto, Ont.
R. A. McComb	Toronto, Ont.
Harris McPhedran	Toronto, Ont.
Robert T. Noble	Toronto, Ont.
R. V. B. Shier	Toronto, Ont.
F. W. Routley	Toronto, *Chairman.*
Harvey Agnew	Toronto, *Secretary.*

Mr. Chairman and Members of Council:—

The special committee on Group Hospitalization begs to submit the following report on the subject of Group Hospitalization, or The Periodic Payment Plan for the Purchase of Hospital Care. It is our hope that the recommendations in this report will enable our hospitals to develop those forms of group hospitalization, where such would seem indicated, which will give the most benefit to all parties concerned, and

which will avoid certain actual and potential dangers observed in some plans, as hitherto developed. In addition to the report, as submitted here, there has been prepared an appendix, which provides examples of contracts and other forms used in such plans, and which also gives statistical and other information of value in setting up a plan.

GROUP HOSPITALIZATION OR THE PERIODIC PAYMENT PLAN FOR THE PURCHASE OF HOSPITAL CARE

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SECTION ONE

INTRODUCTION

An increasing interest on the part of the hospitals and the public in the subject of *group hospitalization*, or the *periodic payment plan for the purchase of hospital care*, the increasing number of centres in Canada and the United States in which one or more hospitals have launched or are about to initiate plans of this nature, and the obvious inference that any group financial arrangement between hospitals and the public is not only of interest but of potential concern to the medical staffs of such hospitals, to the medical profession at large and also to the general public, have led the Canadian Medical Association to the decision that a special committee should be appointed to study this subject. The report of this committee is herein submitted.

DEFINITION

That form of hospital insurance with which this committee is primarily concerned is that, in which, with varying details, *groups of individuals make regular periodic payments to a common fund in return for which subscription such individuals (and in many instances their dependents) receive free hospital care for a specified period of time in one or more designated hospitals.* It is essentially a mutual plan whereby the financial uncertainties and hardships associated with hospitalization are partially or fully removed from the shoulders of the individual and distributed over the group. In the type under consideration charity is not considered as a factor in providing hospital service; these plans are designed to provide adequate payment to hospitals for the service rendered.

Contracts are drawn up whereby subscribers agree to contribute to the fund a certain sum monthly, quarterly or annually; this may be collected in various ways. The hospital or hospitals agree(s) to provide a specified type of hospital service. The type of accommodation is defined, as are also the inclusion or otherwise of dependents, maternity care, operating room charges and other extras, length of hospitalization provided, diseases excluded, etc. The arrangement may be with one individual public hospital or with several or all public hospitals in the community. The collected fund may be directly operated and controlled by the participating hospital(s), by a joint board including the subscribers, or may be sponsored by a private lay organization paying the hospital(s) on a basis of service rendered. Enrollment may be limited to groups, usually employed, or membership may be extended to individuals. There may or may not be a waiting period.

SECTION TWO

A REVIEW OF EXISTING PLANS FOR GROUP HOSPITALIZATION

A. IN THE UNITED STATES

The plans developed in the United States are considered first in this brief review partly because of the greater variability of the plans offered, partly because of the valuable analyses of these experiences now available and partly because of the probable influence which these developments will have upon the future Canadian picture.

While scattered hospital benefit plans have existed for several decades among the employees of large industries, the possibilities of extending this plan to public hospitals in general was first given wide publicity by the development of a plan of group hospitalization by the Baylor University Hospital in Dallas, Texas, in 1930. This hospital had such success and the subscribers were so well pleased with this one-hospital plan that very quickly other hospitals or groups of hospitals in various parts of the country developed plans.

This rapid spread may have been stimulated by (*a*) the necessity of evolving some plan to ease the cost of sickness to the individual, an emergency which has been rendered more articulate by the current vogue in press articles of criticizing hospital and medical costs; (*b*) the financial plight of our hospitals; and (*c*) the closer binding of the hospital field by hospital associations and special journals, thus permitting greater cooperation and interchange of ideas.

At the present time plans are in operation in San Antonio, Houston, Louisville, Newark, New York City, New Orleans, Los Angeles, Sacramento, Washington, Rockford, St. Paul, Kansas City, Akron, Memphis,

Charleston, Cleveland and many other centres. Recent data would indicate that there are approximately 75 plans in operation involving some 150 hospitals and representing over 100,000 subscribers. Enrollment is steadily increasing and almost every hospital journal reports the launching of additional plans. Dallas now has over 20,000 people covered by the plan. The Goodyear Rubber Company plan (Akron) had (in October, 1933) some 17,894 members and over 50,000 people are covered by hospital insurance; New Orleans has over 18,000 members including dependents; Houston and San Antonio have over 6,000 subscribers each; the New Jersey and the Cleveland plans already have over 8,000 subscribers; other recently launched plans in large centres are already showing very rapid enrollment.

About half of these plans represent joint hospital participation; for instance in Cleveland twelve hospitals participate, while in the Essex County, N.J., plan twenty-two hospitals are included. On the other hand Dallas, Texas, has four separate and distinct plans operated for as many hospitals and many other centres have a similar arrangement. However, there is a general trend to deprecate this undesirable feature, necessary though it may have been to get action during the pioneer stages. There is now a distinct tendency, for instance in California, to make the benefits in a plan apply to hospitals in several adjacent centres. The Goodyear plan now gives hospitalization privileges to all members scattered throughout the world.

CONTROL

This has been the cause of some concern in various United States centres because of the endeavours of outside groups to induce the public and the hospitals to participate in plans promoted primarily for personal profit. Strong disapproval of such control has been voiced by the American Hospital Association. While various forms of initial sponsorship may be warranted, that form of control which has met with widest approval is a non-profit organization, developed for the purpose and including representatives of the subscribers, the hospitals, the medical profession, etc., or developed as an activity of an already existing hospital council or other interested body. The hospital(s) may conduct the business directly through existing channels as in Kansas City Research Hospital, may appoint a business manager as in Cleveland or New Jersey or the administration may be independent of the hospitals and the latter be reimbursed at so much per diem only, as in San Antonio and Houston. Some large concerns, as for instance in the coal mining and rubber industries, have very extensive group hospitalization plans which are directed by the employees themselves. In Detroit and in Alameda County, California, the plan is sponsored by the medical profession. The Detroit plan, which is operated by the Wayne County Medical Society is not exactly a group hospitalization plan. It is an arrangement whereby the cost of medical, hospital, dental and nursing care to small wage-earners is spread over a number of small instalments*

Dr. Rufus Rorem, the well known authority on the subject of group hospitalization, has well stated that:

> "In any given plan, the method of promotion and administration should be such as to provide the lowest proportionate overhead costs, and to provide the highest possible proportion for the participating hospitals. In some instances this may be achieved by employing only full-time and permanent executives and field representatives. In other cases, the services of permanent employees might be joined with the temporary services of individuals or private agencies with skill and experience in introducing city-wide financial programs such as community chest or building fund 'drives'. In other cases, private agencies may be engaged to assume full charge of the details of promotion and administration under the direct sponsorship and control of the executive committee of the non-profit association. The suitability of a particular agency to promote and administer a group hospitalization plan would be influenced by such factors as their knowledge of hospital problems, the reputation of the firm, the skill and experience of the individuals available to serve, the prospective period of employment and the amount of remuneration expected."*

RATES

These vary widely, largely because of the variation in services provided and local costs. An average fee for the subscriber alone would be perhaps $8.00 to $10.00 per annum. However, some are several dollars higher; Sacramento and San Jose, California, charge $12.00 per annum. When the rates are higher ($15.00 to $25.00) dependents are usually included. Some have lower rates; the Cleveland plan costs $7.20, the Baylor plan $6.00 while the Goodyear Rubber plan, covering over 15,000 employees, costs but $3.60 per annum; however at this new low rate some call is being made on the large reserve fund. The General Electric Company plan at Fort Wayne contributes $3.50 per diem for 21 days towards the hospital bill for five cents a week. In some plans there is a registration fee of from one to three dollars. This helps to defray the extra overhead associated with developing the plan and obtaining initial enrollment.

Some hospitals offer a double rate; for instance the New Orleans plan has a $9.00 subscription rate for public ward accommodation and a $12.00 rate for semi-private accommodation. It is interesting to note that the higher rate is in much greater demand. In most instances, higher priced accommodation can be obtained by paying the difference in room rates. Some rates are payable monthly, others quarterly, and some annually. Some give a certain reduction where a large group of individuals come in together, or, later, for groups with a good health record.

BENEFITS

Here there is considerable variation, but many contracts provide very similar benefits. Hospitalization is almost always only upon the request of a licensed practitioner. Most contracts limit the number of days of hospitalization in any one year. Three weeks or one month would seem to be the usual limits although some contracts permit much longer hospitalization. In some the number is increased each year. Statistics indicate that twenty-one to thirty days will cover 90 to 95 per cent of cases. However some plans offer a substantial discount to subscribers requiring hospitalization in excess of the designated maximum. The type of accommodation is specified; this varies widely but is usually of a semi-private nature. Ordinary hospital care is provided, including routine nursing, ordinary medicines and dressings, the use of the operating room. Some plans provide complete service, including radiology, basal metabolism, pathological laboratory studies, electrocardiography, oxygen therapy, etc., but where these are not included or definitely

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* *American Medical Association Bulletin*, 1935, **30-1**: 11.

* Hospital Care in the Family Budget, C. Rufus Rorem, Ph.D., C.P.A., American Hospital Association, Chicago.

limited, the cost of "extras" is usually discounted from 25 to 50 per cent.

Most plans limit also the diseases or conditions for which the service is given. Alcoholism, or accidents resulting therefrom, mental diseases, venereal disease, and placardable disease (quarantinable) are usually excluded. Tuberculosis may be excluded also, largely because of the lack of facilities in the contracting hospitals. Ambulatory diseases are not usually included, although discounts may be allowed to subscribers for diagnostic studies. Some plans do not include maternity care. This may be largely because so many of the schemes, being still in the pioneer stage, limit membership to "employed" individuals only. Where dependents are enrolled, maternity benefits are frequently included; where maternity benefits are not included, and also where dependents are not enrolled, maternity hospitalization for the subscriber or a dependent may be subject to a discount. Where dependents are not included many plans provide special discounts for them in case of hospitalization.

A "waiting period" of a few weeks is often required to minimize unfair imposition upon the fund. In some plans this is waived provided the individual concerned has entered as a member of a group not as an individual. For obstetrics the waiting period may be set at ten months. In some plans non-urgent surgery such as ordinary herniotomy or tonsillectomy may be excluded. Some permit surgery for chronic conditions only after a membership of from six months to one year.

PAYMENTS TO PARTICIPATING HOSPITALS

Several methods have been developed based to a large extent upon the type of control of that particular plan. Where a single hospital directs the plan, it sets the premium at a figure which it is anticipated will return a per diem remuneration approximately equal to cost. The hospital assumes this risk. Where several hospitals participate, it is a frequent arrangement to have the premiums paid into a common fund, controlled either by a joint committee, a joint subsidiary company, or, in some cases, a private organization. From this "pot" the hospitals are reimbursed at so much per patient day, the total being in the ratio of their service to the subscriber. Many of these funds pay the hospitals five to six dollars per patient day for semi-private care (charges average higher in the United States than in Canada).

Where the fund has been recently organized or where a sufficient reserve fund for contingencies has not been set up it is sometimes arranged that the hospitals receive at the time but a portion, say, two-thirds or three-quarters, of the agreed per diem remuneration. At the end of the year, if hospitalization has not been abnormally heavy and funds be available, the hospital payments are completed in full; if funds be inadequate the remaining funds are apportioned to the hospitals in the ratio of their service to subscribers. This has seemed quite acceptable to the hospitals concerned; so far funds, judging by reports, have proved adequate, and moreover hospitals are aware of the fact that, without the fund, remuneration for these patients would probably average much less than would be returned by the group fund, even though final payments be reduced.

ABILITY TO MEET CONTRACT

The question has frequently arisen, "What would happen should an epidemic or major catastrophe so overwhelm the hospitals that facilities for hospitalization be inadequate?" This has been considered in many contracts and a frequent provision is that, should the hospital(s) not be able to provide a subscriber with hospitalization on demand, such subscriber shall be returned his premium for the preceding twelve months. This would seem fair enough, as the benefits are not cumulative but are based upon the twelve month period only.

COST OF ADMINISTRATION

This depends upon several factors; *e.g.*, whether the hospitals themselves direct the plan, employ an agency or contract with an independent body; whether or not membership is limited to employed groups; the method of collecting membership dues; and the ease or difficulty of obtaining public support for the plan. Also it is obvious that the cost of initial enrolment of subscribers will be (or should be) much higher than the cost of continuing membership or of obtaining new members in subsequent years after the movement has gained impetus and recognition.

Reported costs indicate a wide variation. Many of the plans now in operation in smaller centres in Canada report no administrative overhead, as collections are made by voluntary group representatives or by company pay-roll deductions and the hospital office staff handle other details. At Kamloops the cost is 7 per cent. In New Orleans an outside collection agency gets paid $2.00 for new members and $1.00 for annual renewals. One dollar also is set aside for administration. This is a temporary arrangement. The Cleveland plan costs are now between 20 and 25 per cent, but it is expected to reduce this to 10 to 15 per cent. The Newark, N.J., cost of operations during the first year of operation were $1.53 per application. Baylor University Hospital reports a cost of 4 per cent. The Durham, N.C., plan cost was 29.7 per cent at first; later this fell to 17.6 per cent. At San Antonio, Texas, where there is an outside organization, the cost is 35 per cent; this includes ambulance service. The cost, too, would seem to be higher in the more extensive plans in large cities, where mass public approval is more difficult to arouse and where full time paid staffs are necessary.

CERTAIN RESERVATIONS REQUIRED IN APPLYING UNITED STATES HOSPITAL EXPERIENCE TO CANADA

One factor which must be borne in mind in applying to the Canadian situation the experiences of hospitals in the United States, is that there is a considerable, almost a fundamental, difference in the two hospital systems. In the United States, particularly in the larger towns and cities the common arrangement is that non-pay patients go to certain municipally owned hospitals, most of which do not accept private patients in the usual sense. Pay-patients go to other hospitals, some of which are of a voluntary non-profit nature—the usual type of public hospital in Canada—but many of which are proprietary and operated for profit. In Canada practically all of our "public" hospitals, only a few of which are municipally owned, admit both pay and non-pay patients and where municipal or civic, and voluntary non-profit public hospitals operate in the same community, both accept private and non-pay patients, both receive provincial grants and, in most instances, the voluntary hospital receives the statutory grant from the local and other municipalities for the care of indigent and non-pay patients.

B. IN CANADA

The following urban and rural centres in Canada have adopted some form of group hospitalization. The majority of these date back but a few years but some, for instance in Glace Bay, N.S., have been in existence over thirty years.

GROUP HOSPITALIZATION PLANS IN CANADA

	Hospital
Nova Scotia	
Glace Bay	St. Joseph's or Glace Bay General (separate).
Inverness	Inverness County Memorial or St. Mary's Hospital (separate).
New Glasgow, Stellarton, Trenton, Westville	Aberdeen Hospital, New Glasgow.
Sydney Mines	Harbour View Hospital.
Sydney	St. Mary's Hospital.
New Brunswick	
Bathurst	J. H. Dunn Hospital.
Ontario	
Kingston	Kingston General and Hôtel-Dieu Hospitals (choice).
Cobalt	Cobalt Mines Hospital.
Fort William	McKellar General Hospital.
Toronto	(under consideration).
Saskatchewan	
Yorkton	Queen Victoria Hospital.
Wadena	Wadena Union Hospital.
Alberta	
Lethbridge	St. Michael's Hospital or Galt Hospital (separate).
Edmonton	Royal Alexandra Hospital. University Hospital. Miséricordia Hospital. Edmonton General Hospital.
Drumheller	Drumheller Municipal Hospital.
British Columbia	
Nanaimo	Nanaimo General Hospital.
Duncan	King's Daughters' Hospital.
Port Alberni	West Coast General Hospital.
Kamloops	Royal Inland Hospital.
Invermere	Windermere District Hospital.
Merritt	Nicola Valley General Hospital.
Nakusp	Arrow Lakes Hospital.
Campbell River	Lourdes General Hospital.
Bella Bella	R. W. Large Memorial Hospital.
Kelowna	Kelowna General Hospital.
Trail	Trail-Tadanac Hospital.
Chemainus	(under consideration).

TYPES DEVELOPED IN CANADA

The first experiments were developed around basic industries as, for instance, mining. Membership is still limited in some instances to employees of these large companies but in other plans it is extended to any group and in some instances to individuals. For instance the Kamloops plan, although still very young, has already enrolled over 500 farmers. The New Glasgow plan accepts employees of local stores.

A distinct departure from the conventional plan is that of the two hospitals at Kingston, Ontario. In this joint plan the fees are kept low ($5.00 for the first member, $2.00 for the 2nd family member and $1.00 for the remaining members of the family) and benefits are paid, not at the time of hospitalization but at specified six months' periods. A pro rata distribution of one-third of the fund is made at the six months' interval to subscribers submitting hospital receipts; at the end of the year, the full amount in the bank (if necessary) is then divided among the subscribers hospitalized during the year on the basis of their receipted accounts, less the six months' interim payments. The maximum benefit for the year is $100 for an individual member and $150.00 for a family membership.

An effort to discourage unnecessary hospitalization and thus help both parties has been made by the St. Michael's Hospital at Lethbridge, Alta., and an opportunity to compare it with the more usual plan is afforded in the same community. Whereas the local Galt Hospital charges $12.00 per year, St. Michael's Hospital charges $6.00 per year for practically the same benefits, but charges the subscribers and dependents $1.00 per day for the specified public ward care. This permits a lower subscription rate and would seem fair to the subscribers. Whether or not it will result in less hospitalization as compared to the orthodox plan as followed locally at the Galt Hospital will be determined in due time.

An all-inclusive form is that of the Civil Service Association of Ontario, described more fully on page 35.

RATES AND BENEFITS

INDIVIDUAL HOSPITAL PLANS

These vary considerably with the hospital and the area served, but on the whole are lower than those prevailing in the United States.

Glace Bay with over thirty years' experience maintains a rate to the miners of thirty cents per week for public ward hospital care (there is also a "drawback" for the doctors' services of forty cents a week—a separate arrangement). This fee covers dependents also; if a private ward be desired there is a 50 per cent reduction. The director of one of the two Glace Bay hospitals writes: "The scheme is giving entire satisfaction to both the hospital and the subscribers."

At New Glasgow, Nova Scotia, the charge is 75 cents per month for the subscriber and family; public ward accommodation is provided, with a $1.50 deduction from private room rates and $1.00 per diem deduction from maternity rates. This rate was quite recently raised from 50 cents a month because the hospital was losing money on the former arrangement. In 1933 at 50 cents per month the contract revenue was $17,342.80 while the contract service provided amounted to $23,383.88. A doubtful feature here is that the doctors rotating on the public ward service are asked to give free medical care to subscribers if required. However, most patients have their own doctor.

At Sydney Mines the miners pay 20 cents per week. Dependents are included, also certain extras such as x-ray examination. Private room rates are reduced from $3.00 and $3.50 to $1.00 and $1.50 to subscribers.

At Inverness, N.S., where local townspeople and farmers as well as the miners may participate, the rate is 50 cents per week, entitling the subscriber to public ward care or to a private room at $9.00 per week. There is a 50 per cent reduction for dependents and also for all extras.

The Nanaimo, B.C., plan charges 50 cents per month for persons without dependents and 75 cents if dependents be included. Six months' illness in any twelve consecutive months is recognized and there is a three months' waiting period. The public ward rate ($2.25) is charged against the hospital by the fund. Maternity and certain diseases are not included. A feature is that emergency care in another hospital is paid for on the above rate. There are 650 members and in 1933, after seven years' operation, the fund had a surplus of $2,500.

The Kamloops plan, developed to prevent the financial insolvency of the hospital, for $12.00 per year gives up to three months' hospitalization on the public ward to subscribers and dependents under 21 years of age; extras are included. Over 1,400 subscribers are now enrolled.

At Invermere, B.C., a small hospital, serving a scattered population in the Columbia valley and the one local doctor have developed a plan which includes medical service. To some extent it could be considered as a panel practice with hospital care included. For $1.00 per month an individual receives free care in the hospital

or at the doctor's office; $1.50 covers a married couple and $2.00 per month provides a family ticket. Hospital care is limited to sixty days per annum. Maternity care, infectious diseases, V.D., or alcoholism are not included.

Port Alberni, B.C., for $9.00 gives three months' public ward care to each subscriber, his wife, and dependents not over 17 years of age. Maternity care and extras are included. This fund has 1,500 contributors and the paper surplus in 1934, after charging regular rates on all admissions was approximately $2,000.00. It is interesting to note this surplus, for a rate of 75 cents per month for a family is comparatively low.

The plan at Wadena, Sask., costs $4.00 for the individual and $7.00 for the family. A large proportion of the 1,000 families enrolled contribute through the taxes.

At Drumheller the $9.00 fee covers dependents as well. It is collected by the mine office in three installments, usually in the fall months. X-ray examination, laboratory, operating room and case room are included. If a contract holder be also a hospital ratepayer the hospital tax is refunded to leave the amount of the miner's fee. Hospitalization has increased, but both parties are satisfied. The return to the hospital is small, but is better than could be anticipated otherwise.

JOINT HOSPITAL PLANS

The plan developed jointly by the four large hospitals in Edmonton has a rate of $7.20 per member. Dependents (who may be listed to complete minimum groups of five) are charged $6.00 unless under 15 years of age when the rate is $3.00 per annum. Thirty days on the public ward is provided, with semi-private accommodation $1.00 extra, and private, $2.00 extra. Hospitals are paid $2.50 per patient day. Laboratory, operating room and case room included; x-ray and physiotherapy half rates. (See appendix).

The Kingston plan has been described above.

AN ALL-INCLUSIVE PLAN

A plan which may be of considerable significance is that launched this year by the Civil Service Association of Ontario. An incorporated company has been set up by a committee of this body to furnish to subscribers: (*a*) three months' hospitalization in a semi-private ward with x-rays, anæsthetics and operating-room charges covered; (*b*) surgical benefits (cost of highly specialized types of operations, however, but partially covered); (*c*) medical benefits, including home, office and hospital visits and calls; (*d*) nursing—special, home or hourly; (*e*) dental benefits, limited to semi-annual inspections, ordinary fillings and extractions and dental surgery up to a total of $15.00 in any one year. A physical examination, on application, is furnished; there is a three months' waiting period, and there will be free choice of doctor and hospital. The fee for this service is two dollars per month per adult. If two adults in one family are members, children under sixteen may be enrolled at $1.50 for office visits and $1.00 for hospital visits. At present the plan is limited to members of the Civil Service in the Toronto area, but it is proposed to extend the arrangements shortly to the whole province. This plan is not sponsored by the provincial government; it is a venture of the civil service workers themselves.

COLLECTIONS

Where groups are employed in large industries; *e.g.*, mining, lumbering, etc., deductions may be made from the wages by the firm management. Small insured groups, such as shop employees or neighbours, sometimes arrange for one of their number to pay the hospital regularly for the group. At Invermere the local bank has agreed to deduct the monthly subscription from the accounts of subscribers; for the Kingston plan, payments may be made to any bank manager in Kingston, Napanee or Gananoque. In most instances payments are made by individuals or groups to the hospital, to the manager or secretary-treasurer of the fund, or, in some instances, to a representative or salesman of the fund who may work on a part-time or a commission basis. At Kamloops collections are for two month periods and barter is allowed. Authorized collectors are not paid but are given free insurance if twelve subscribers obtained.

RESULTS

Group plans have been in operation sufficiently long in a number of Canadian centres to gain some opinion of their effect. As far as this committee has been able to ascertain there would seem to be general agreement that the plans now in operation have proved of direct benefit to both the patients and the hospitals and of indirect benefit to the medical profession. In some of the mining areas unemployed miners have been very particular about keeping up their eligibility and the steady income has been of definite assurance to the hospitals. An indication of the preventative aspect of these plans is evident in Glace Bay, where the two hospitals contribute heavily to the support of the district nurses, it being recognized that the services of these nurses help to keep the subscribers and dependents out of hospital or permit earlier discharge of insured patients to their homes. The possible effects upon the medical profession will be considered in Section IV A.

C. IN GREAT BRITAIN

British experience is commented upon here because, while there is considerable difference in the principles of the plans developed in Great Britain and on this continent, much valuable information and many applicable suggestions can be gained from the experience in the British Isles.

The development of the panel system, beneficial though it was to many groups concerned, did not solve the problem of the *voluntary hospitals* whose non-remunerative work was if anything increased by the new arrangement, nor did it solve the problem of illness costs for that large group of the public with small incomes ranging above the panel limit. To meet these needs, particularly the latter one, supplementary and voluntary plans were developed.

PROVIDENT PLANS

Two types of organizations have resulted, (*a*) *provident* plans and (*b*) *contributory* plans. The "provident schemes" which have been given special study by the British Medical Association, constitute a form of mutual insurance developed especially for the middle and professional classes to provide financial assistance to cover (1) hospitalization in various types of hospitals and (2) professional services. The British Medical Association recommends a graded maximum income, £375. for members without dependents (cost £1. 18s.) to £550. for members with more than one dependent (cost £3.).

A typical example is the British Provident Association* (B.P.A.). Subscribers may join one of three groups: Scheme I, for a rate of 1 guinea for a single person to 2 guineas for a married couple with children may draw up to £5. per week for 3 weeks of hospitalization, up to 3 guineas per week for 3 weeks for a nurse at home, up to 3 guineas for a consultation fee at home and the sharing of radium, ambulance and other costs. In Scheme II, where the annual rate is £2. 16s. for a single person to £6. 12s. for a couple with one child (£1. extra for each additional person), the benefits are as in Scheme I but there is a contribution according to a fixed scale towards surgeon's fees to a maximum of £100. In Scheme III the rates are as for Schemes I or II plus an additional amount of either 12s. 6d. or

* The British Provident Association for Hospital and Additional Services, 30 Lancaster Gate, London, W.2.

18s. 9d., and the additional benefits include up to 1 guinea per day up to twenty days for the services of a consulting physician (other than usual physician). A "founders'" certificate (£5. for a single person or £10. for a married couple) gives such individual(s), for life, prior claims to accommodation and hospital charges at cost of maintenance. This plan has met with widespread approval and support.

The Oxford plan represents the first attempt in England to adopt these principles to a large agricultural district. The plan embodies: (*a*) a contributory scheme for workers below a certain income; (*b*) a provident scheme covering hospital and medical charges on a fixed tariff scale; and (*c*) a contribution towards the hospital charges for well-to-do persons. Each village has been invited to form its own hospital aid committee with local officers and collectors.

CONTRIBUTORY PLANS

These differ from the provident plans described above in that they do not pretend to be self-supporting as is the objective of the provident plans. To quote M. D. Mackenzie*: "The contributory schemes are run entirely in connection with the voluntary hospitals and constitute a combination of self-help and charity. Contributors are asked to join a contributory scheme on one or more of the following grounds:—

1. As an insurance against sickness and as a means at the same time of helping the hospital;
2. On the ground that, when they need admission, contributors had paid towards it and will not be accepting charity;
3. That the hospitals are principally for the use of wage-earners and their contributions should give them a sense of independence in using the hospitals;
4. To assist hospitals in maintaining a regular source of income."

The English contributory funds now contribute to the voluntary hospitals about £2 per week per patient, or about 70 per cent of the average actual cost of maintenance, although the Oxfordshire plan pays its hospitals £3. 10s. per week per in-patient. In 1933, ten leading contributory schemes, with a total of 2,839,000 contributors (aside from dependents) contributed £1,161,737 to voluntary, municipal and convalescent hospitals. There is a growing consciousness, according to Mr. Sydney Lamb, the well known Liverpool authority on this subject, that these plans should meet the full cost of the maintenance of the contributors in voluntary hospitals.

These contributory plans provide hospitalization if needed but do not guarantee available accommodation. There is a general acceptance that about £312 should be the limit of income for subscribers. The usual contribution is 2d. or 3d. per week. Some of the plans are under the control of the hospitals but the majority are not. The usual contribution is about £1 per annum paid in small installments. Hospitals usually provide free public ward hospitalization with discounts for private rooms, while in those plans not under the control of hospitals, a contribution (grant-in-aid) towards hospital care is usually made. Such may be applicable in either voluntary or Council (municipal) hospitals. Over seventy of these organizations are members of the British Hospitals Contributory Schemes Association, representing in 1932 a membership of approximately 3,500,000. At that time the total membership of all contributory plans was approximately 6 million.

HOSPITAL SAVING ASSOCIATION

Of the tremendous numbers of contributory plans which have sprung up all over England, one of the most important is the Hospital Saving Association (The H.S.A.). This great organization, with approximately one and one-half million members, is a non-profit body covering the hospitalization not only of panel members but of their families and of workers in non-panel categories. Membership is confined to individuals whose income is limited to £4 per week if single, to £5 if married and without children under sixteen, and to £6 if married and with children under 16 years of age. The contribution is 3d. per week (12s. per annum in advance), and some employers add 1d. per week. Members and dependents, who have a wide choice of hospitals, are relieved

(*a*) from enquiry at hospital as to means;

(*b*) from any payment in an ordinary ward (ten weeks' limitation at certain special hospitals); and

(*c*) from any payment as an out-patient.

If treated at other than a listed hospital, the patient will be reimbursed (within certain limitations) normal payments for a period not exceeding ten weeks. Other assistance is made towards the cost of dental care, surgical appliances, glasses, ambulance service and convalescent care. Normal maternity care is not included.

Persons with larger incomes may join by paying £1 annually in advance. Such contributors obtain hospital reimbursements up to £10 for each illness, plus other assistance. Hospitals are paid 4s. per day for in-patients and the average cost at that hospital for out-patients.

The Sheffield Experiment, one of the earliest of all, has enrolled 200,000 subscribers since 1921, despite an unprecedented industrial depression, and has raised the hospitals' income from £71,424 (deficit £51,504) to £141,663. There has been some increase in expenditure but the annual deficit has been reduced from £51,504 down to £6,320.

The Birmingham plan, with nearly a half million contributors out of one million inhabitants, pays the hospitals in its area 78 per cent of the cost of treatment to contributors. The rate is 3d. per week. The district nurse is paid 9d. per visit to the homes and there is a 20 per cent reduction off appliances, etc.

The "Penny in the Pound" plan of the Merseyside Hospitals Council is a remarkable example of what can be done in a seaport area like Liverpool and Birkenhead despite widespread unemployment and distress. The basis is a graded scale of rates willingly accepted by the members; one penny is paid per week for every pound of the weekly wage. Employers usually contribute one-third. In 1933 there were 274,090 contributors representing 700,000 people. Contributions are made through special stamps easily purchased and affixed to a card. Twenty-one voluntary hospitals in the area participate and benefits include: Hospital care. Convalescent care. Spa treatment for arthritis, etc., (Buxton, Harrogate). Home nursing. Extra nourishment at home (six weeks). Surgical appliances (repayment by installments if possible). Crutches loaned. Invalid chairs and sick room equipment loaned. Children of sick mothers cared for or a housekeeper placed in the home. Cash allowances obtained for family when breadwinner ill. Free clothing provided if necessary. Ambulance service. Five cars carry 14,000 patients annually. A night volunteer motor service is maintained by 200 private car owners to transport patients' relatives and blood donors. Social service visits. Casualty and emergency service by the hospitals. Out-patient privileges are confined chiefly to special consultations, although they are freely extended to the unemployed and the poor. A medical statement is required.

This plan is not so sound actuarially as its sponsors would desire as it can pay the hospitals but 62 per cent

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* Mackenzie, M. D., Recent Tendencies in the Development of General Hospitals in England, Quarterly Bulletin of the Health Organization League of Nations, III: 2, June, 1934, p. 220-288.

of the cost of contributors' care. With a higher contribution, when economic conditions improve, this difficulty could be overcome.

Writing of the British contributory plans, Michael M. Davis, Ph.D., Director for Medical Services, Julius Rosenwald Fund, Chicago, states: "We have much to learn from the British schemes by studying their broad basis of community organization, their economy in administration, and the manner in which they have increased the payment for hospital care of small wage earners through systematic weekly budgeting . . . The British contributory plans are universally regarded as having saved the voluntary hospitals financially . . . Even the financial safeguarding of the voluntary hospitals, however, is of less significance than is the establishment of a new relationship between the hospitals and millions of wage earners, based on cooperation for mutual financial security and enlarged mutual service."*

APPLICATION HERE OF BRITISH EXPERIENCE

These British plans are of value in this study in that they reveal how extensive and varied are the plans operating in England to finance hospitalization for employed workers and lower salaried professional groups. There is one fundamental distinction between British contributory schemes and the group hospitalization plans developing here; our plans endeavour to be, and should be, quite self-supporting, while the British contributory plans do not contribute more than a portion of the average in-patient per diem cost—they are designed to assist the financing of the voluntary hospitals and to preserve the British workman from pauperization and give him a salutory feeling that he is contributing to his hospital maintenance. The H.S.A. pays the voluntary hospitals but four shillings per patient day while the actual cost averages between eight and eleven shillings per diem. This would furnish one reason why contributions in Canada (where very few hospitals are endowed) must be higher than they are in England.

Another factor of note is that most of the plans in England do not provide for payment of the medical staffs of voluntary hospitals. True some permit the staff members to charge modest fees to contributory fund members and some apportion a percentage (20 per cent for example) to the staff, but the lack of payment in the majority of instances has resulted in a joint protest from the British Medical Association and the British Hospitals Association which bodies feel that a portion of the funds collected should be set aside for the reimbursement of the medical attendants.

A study of these British plans is of value also in that it reveals how wide can be the scope of the benefits allowed. Undoubtedly from the viewpoint of the subscriber it is of real value to have a wide choice of hospital, ambulance service, district nursing, free (or partially so) surgical appliances, convalescent care, special rates for consultant services, etc. In Canada localized and limited experiments may be anticipated in these early stages, but ultimately a wide-spread cooperative type of hospital insurance with widely inclusive hospital and nursing benefits would seem desirable.

SECTION THREE

ADVANTAGES AND DISADVANTAGES OF THE PERIODIC PAYMENT PLAN FOR HOSPITAL CARE

ADVANTAGES

The following advantages have been outlined by Mr. Frank Van Dyk of the Associated Hospitals of Essex County, N.J., based upon the Newark experience and that of other plans elsewhere, the bracketed phrases having been interpolated:

1. It enables employed persons of average means to be assured of adequate hospital care at no other cost than a monthly payment which averages no more in many instances than the cost of a newspaper a day.
2. It enables them to obtain the scientific advantages of hospital service at an early stage of illness and thus avoids advance of illness to a degree where intensive hospitalization or medical care is required.
3. It avoids the necessity of the patient's going into debt, or accepting charity service.
4. It enables him to retain his self-respect and saves him from the spectre of financial insecurity. (There is also a distinct moral value in that it helps to prevent pauperization.)
5. It enables the hospital to place its financial structure on a more permanent basis.
6. It tends to increase occupancy of private accommodation, (even though such be not included in the plan).
7. It yields an income (to the hospitals) in excess of the cost of care. (This applies to American plans.)
8. It enables the hospital to admit to private accommodation many persons who otherwise would receive ward service (either by inclusion in the plan or by extending the privilege for a small additional sum.)
9. It preserves the independent practice of medicine and enables the doctor to establish and maintain a private relationship between the patient and himself.
10. It enables the doctor to have the advantage of the hospitals' scientific facilities which otherwise might not be obtained because of the inability of the patient to pay for such service.
11. It enables the doctor to collect his fees more readily.
12. It also enables the doctor to retain many of his patients who otherwise might be lost to him, because of their inability to pay for private hospital service.

To these should be added:

13. By lessening the financial burden of sickness to that group upon which it is the greatest hardship, group hospitalization plans remove or at least diminish one of the major factors behind the demand on the part of a large portion of the public for the inauguration of "state medicine". *Group hospitalization should be looked upon as an antidote to, rather than a precursor of more radical forms of socialized medicine.*
14. A well controlled plan should help to raise the standard of professional work in the hospitals concerned by admitting to the organization only those hospitals with a high standard of professional efficiency and control and by the requirements and recommendations of the subscribers.
15. The increased interest of the subscribers in the welfare of their hospitals and in health problems generally should be of mutual benefit to both parties.
16. By reducing hospital deficits, fewer and smaller requests for assistance will have to be made to municipal bodies or to community chests or other sources of charitable funds.

* Davis, M. M., English Workmen Pay Their Hospital Bills, Modern Hospital, Chicago, XLII: 2 (Feb., 1934), pp. 37-42.

17. A major share of the financial support of public general hospitals would still be provided by the public rather than the state, thus reducing the possibility, albeit a remote one, of political control of our institutions.
18. One hospital administrator comments on the relief of not having continually to send out bills for hospitalization.
19. Experience has proved that many patients who could not pay a hospital bill in the ordinary way have little, if any, difficulty in paying small amounts periodically. Also many of those who might be expected, under ordinary circumstances, to object to paying hospital indebtedness have been found quite willing to pay on the periodic basis.

POSSIBLE DISADVANTAGES OF OR OBJECTIONS TO GROUP HOSPITALIZATIONS

The following possible objections to the periodic payment plan for hospital care have been collected and should be kept in mind in evaluating any proposed plan. Some are based upon past experience of various plans, while others suggest potential dangers.

1. Many plans are initiated without adequate provision to set up reserves, to minimize operating expenses and profit, to keep the rates actuarially sound, or to ensure protection of and control by the subscribers and the hospitals.
2. Should the rate be too low or the hospitalization be heavy the hospitals participating would lose financially.
3. If all public hospitals in a community are not members, the normal clientèle of other hospitals may be affected.
4. It is not sound to have a commercial organization, interested primarily in profits, intervene between hospital and patient.
5. A voluntary plan is comparatively costly because of the greater willingness of the physically weak to participate.
6. If hospitals are paid so much per patient-day from a common fund, this fund might be depleted by undue retention of subscriber-patients.
7. Hospitals cannot guarantee accommodation in case of epidemic or major catastrophe.
8. Patients not requiring hospital care might insist upon being admitted.
9. Subscribers, not having to pay, would remain in hospital longer than necessary. This, with the likely increased patronage, would overcrowd the hospitals and force additional construction.*
10. Unless participating hospitals extend their facilities to all doctors there would be interference with the free choice of physician by the patient.
11. The influence of lay commercial interests may become so extensive that they may dictate to the members of the medical profession the basis of their relations to their patients and possibly limit the choice of medical attendant.
12. The plan is inadequate, inasmuch as other sickness costs are not included, nor do the plans provide in some instances for the dependents.
13. Group hospitalization is but a precursor of general health insurance or even state medicine.
14. Hospitals are created to treat the sick, and it is held by some that hospitals should not engage in developing financial plans for the public.

COMMENTS ON THE ABOVE ADVANTAGES AND OBJECTIONS

It should be borne in mind that the "Advantages" and "Disadvantages" tabulated above are a composite summary and all would not necessarily apply to any one plan. The *advantages* could be anticipated to the full extent outlined only if great care be exercised in the formulation of a plan and such policies and safeguards be observed as experience has already proved to be advisable. These are set forth under Section VI. (Recommendations, pp. 41-43).

As for the *disadvantages* listed, many of these would apply only to hastily conceived plans, to those without carefully arranged safeguards, and to those developed primarily for the commercial gain of business groups and without adequate control by the hospital(s) and the subscribers. To avoid such situations both hospital and medical leaders have endeavoured to warn and safeguard hospitals against too hasty acceptance of dubious plans and to insist upon certain fundamental requirements. Of most concern to hospitals and the public are those potential disadvantages (if any) which to the reader might seem difficult to eliminate in the most Utopian plan. Epidemics (No. 7) cannot be foreseen and against such contingencies the hospitals must accept some risk; however it is realized that they would probably receive most of such patients anyway and many of them on a less satisfactory financial basis, too.

If dues prove too low, or unnecessarily high, such can be adjusted in the light of experience (No. 2). Education of the subscribers has proved a reasonably adequate safeguard against imposition (Nos. 8 and 9) both on this continent and in England, but complete elimination cannot be expected. It is not ideal that one hospital alone out of several in the community should have a group hospitalization plan (No. 3), but such may be necessary before the other hospitals will venture participation.

As for the objection that group hospitalization would be but the precursor of "state medicine", a viewpoint for which in one sense there would seem to be some justification, it could perhaps be more logically contended that the wider utilization of those forms of voluntary group insurance which would preserve the better characteristics of our present system would act as a deterrent rather than a stimulant to the development of more radical plans, inasmuch as the chief present source of discontent—the financial pressure and hardship—would be to a large extent removed. However, it is realized that fully adequate relief would require a plan to cover medical, nursing and dental costs as well.

SECTION FOUR

THE STATUS OF GROUP HOSPITALIZATION

A.—THE MEDICAL PROFESSION AND GROUP HOSPITALIZATION

This subject is of the utmost concern to the medical profession because of its bearing not only upon the type of service which the patient can be given but also upon the relationship between that patient and his family doctor. The physician appreciates perhaps better than anyone but the patient the financial burden of sickness and would welcome a plan which would remove or reduce hospital costs, at least to the patient of moderate means. The profession also appreciates the value to the patient—

* "Contrary to all predictions the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually, and the continuously increasing duration of such sickness. Various studies in the United States seem to show that the average recorded sickness per individual is from seven to nine days per year. It is nearly twice that amount among the insured population of Great Britain and Germany, having practically doubled in both countries since the installation of insurance." (Simmons, A. M. and Sinai, Nathan: The Way of Health Insurance, Univ. of Chicago Press.)

and to the medical attendant—of having free and ready access to hospital facilities; the better care and the lessened financial worry of the patient mean much to hasten convalescence. The doctor is glad, moreover, to retain many patients in hospital as private patients who otherwise for financial reasons would have to go "under the staff". He knows also, from a purely personal viewpoint, that his own opportunities of collecting something for his professional services are greatly increased if the family has no large hospital bill to meet first before starting to pay off the doctor's account.

At the same time (see section on "Advantages and Disadvantages"—pp. 37-38) the medical profession realizes that unless these plans are carefully developed, particularly in larger centres, difficulties of a more or less serious nature may be anticipated. For instance, some hospitals, usually in the larger cities, do not permit medical fees to be charged to patients on the public wards, even though such patients be paying their own way. Would subscribers choosing such accommodation thus receive free medical care although perhaps quite able to pay for it? Or should the hospital, as has been done, waive such rules for patients hospitalized as "subscribers" and permit medical fees to be charged? Also, where hospitals do not unite but have separate plans or where one only participates, what would happen when the family doctor has staff privileges limited to other than the subscriber's hospital? Should a doctor not on the courtesy staff be given the privileges of the courtesy staff for his subscriber-patients? Would a hospital with a limited or closed staff be required to extend its facilities to any doctor selected by a subscriber? These are details which might not apply in a small centre, but where applicable they should be carefully provided for in any plan adopted (see "Recommendations", Section VI).

When an ill subscriber has no doctor, there is a potential source of friction with non-staff doctors should a participating hospital to which the subscriber appeals recommend one of its own staff doctors. This possible situation would seem to be best met by (*a*) admitting none but emergency cases without a doctor's request for admission (preferably written, but not obligatorily so) and (*b*) by the hospital tactfully declining to recommend a doctor. This situation may be unavoidable in a case of emergency when a staff surgeon or physician must be called hurriedly, but in such instances as free choice as possible might be permitted the subscriber at the earliest opportunity.

From the viewpoint of the medical profession some thought should be given to the possibility of these plans, particularly in cities, becoming so large and so well organized, perhaps under lay executive direction, that the next step would be the employment on a salary or other dictated basis of certain physicians and surgeons to do *all* the work for the subscribers and their dependents. Already this development is quite apparent in industrial medical care. The potential dangers to the public of such a development, as well as to the medical profession and the hospitals themselves, is quite obvious and this emphasizes the necessity of maintaining the closest relationship between the medical profession and any local group hospitalization plans.

While now it is generally recommended that medical or surgical treatment be omitted from the group benefits, it would be logical to expect, if the principle of group hospitalization proves sound and acceptable in the light of experience, an extension of these plans to include *medical* care. Such arrangement, if developed on a fair and sound basis, might assist considerably in solving the financial problem of both the patient and the doctor, should some more generalized plan of health insurance not be evolved in the interim. Such inclusion of the medical profession should only be agreed upon, however, if the basis of agreement does not interfere (within limitations set by professional requirements) with the free choice of physician, or of hospital, or other requirements recommended under Section VI.

The opinion of the medical profession in the United States is divided over the pre-payment plan. The American Medical Association, through its Bureau of Economics particularly, has expressed opposition to sickness insurance and from time to time to the development of plans for group hospitalization. However, it would appear that the concern of the House of Delegates of the American Medical Association at the present time would be chiefly over the possibility of a compulsory form of health insurance. Referring to group hospitalization, Dr. Morris Fishbein has written "The medical profession has never objected to such experiments, provided they are carried out in such a manner as to protect both the patient and his doctor against exploitation and to maintain the quality of medical service". At the special meeting in February, 1935, at Chicago, it was agreed that "the House of Delegates would again emphasize particularly the necessity for separate provision for hospital facilities and the physician's services".

The American College of Surgeons endorsed the following clause, on June 10, 1934, in a report on medical service and economies: "The American College of Surgeons recognizes that the periodic pre-payment plan providing for the costs of medical care of illness and injury of individuals and of families of moderate means offers a reasonable expectation of providing them with more effective methods of securing adequate medical service".* The report also states, "Plans for the payment of hospitalization alone (Class B) without provision for payment for medical service, may be considered the first project to be undertaken in the average community". Several state societies, including Michigan, New York, North Carolina and California as well as various local societies, including the Cleveland and Washington, D.C., Academies of Medicine have approved group hospitalization. In January, 1935, a special joint committee of the Medical Society of the State of North Carolina and the North Carolina Hospital Association outlined an approved plan for a state-wide form of group hospitalization.

The Committee on Economics of the Canadian Medical Association, in its outline of a Plan for Health Insurance in Canada, recommends "that there be offered, on a voluntary basis, to those with incomes above the Health Insurance level, Hospital Care Insurance, and that this be administered as part of the State Health Insurance Plan" (Section XXV of Report). While hospital care insurance, or group hospitalization, may be developed quite apart from any province-wide or other plan of general health insurance, it could fit in readily, if occasion required, to such plans.

B.—Opinions of Other Interested Groups

The Board of Trustees of the American Hospital Association in February, 1933, endorsed the principle of group hospitalization. Since then the Council on Community Relations and Administrative Practice of this Organization, with Mr. C. Rufus Rorem, Ph.D., C.P.A., of the Rosenwald Fund as consultant has made an intensive and definitely favourable study of this subject.

The Committee on the Costs of Medical Care in its final report† recommended that "general hospital service, not maintained by taxes or designed primarily for the wealthy, should be provided wholly or in part on a voluntary insurance basis, individuals or groups in the community paying agreed annual sums and receiving hospitalization when needed without further charge. Such plans will be of wider social benefit if they cover professional fees for hospitalized illness, as well as the charges for hospitalization itself."

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* Report of the Medical Service Board of the American College of Surgeons, Bulletin of the American College of Surgeons, XVIII: 2 (June, 1934), pp. 3-5.

† Medical care for the American People,—Publication No. 28 of the Committee on the Costs of Medical Care, the University of Chicago Press, 1932, page 123.

Other bodies such as the General Federation of Women's Clubs, labour organizations, hospital associations, etc., have endorsed this approach to the solution of the cost of sickness. The American Association of Community Chests and Councils have from time to time made pronouncements in favour of the principle of group budgetting for hospital care.

C.—Legal and Insurance Status

In view of the fact that several proposed plans in various states were delayed until certain complicating state insurance regulations, such as the requirement to post large deposits for public protection, could be revised, an endeavour has been made to ascertain what is or would be the status of group hospitalization of the type considered in this report under Canadian federal and provincial insurance regulations. The following viewpoints have been expressed to the committee:—

Superintendent of Insurance for Canada, (Mr. G. B. Finlayson, Ottawa).

"While there is no doubt some element of insurance in the proposal to which you refer, I am inclined to think that the scheme is not, in its essence, one of an insurance contract, and that for that reason it would not be regarded as coming within the statutory insurance regulations. If the scheme involved long term contracts, I am inclined to think that there might come a stage when the public interest would demand supervision, for the purpose of making sure that advance contributions were being properly conserved and invested to meet the ultimate demands for benefits. So long, however, as the contributions provide only for benefits in the current year this stage is not likely to be reached."

Superintendent of Insurance for British Columbia (Mr. H. G. Garrett).

"I would think that no group hospitalization plan, such as you outline or is described in the pamphlet you enclosed, could be considered as insurance. The essence of an insurance contract is indemnity for some loss and the indemnity is payable in money. The hospitalization plan, on the other hand, merely agrees to provide a subscriber with certain services and not in any event, so far as I can see, to pay him any money, because he happens to sustain loss through illness. The plan is quite distinct from that of a benefit society, for example, where a subscriber is paid so much a week during illness. While I have not had time to consider the matter very deeply, my present view is that there is *no element of insurance* in the scheme."

Minister of Natural Resources for Saskatchewan (Hon. W. J. Patterson).

"I have discussed the matter with the Superintendent of Insurance and after giving it consideration we are of the opinion that a plan such as you suggest would not be considered as insurance and it would not be necessary for any hospital undertaking such a plan to comply with the Insurance regulations in effect in this Province."

Superintendent of Insurance for Manitoba (Mr. Charles Heath).

"I am of the opinion that there is *no* element of insurance in your proposition as I understand it, because an insurance contract is fundamentally a contract of *indemnity* and is so defined in somewhat similar language in Provincial Insurance Acts . . . On the other hand your proposition appears to be one of 'service' rather than 'indemnity'. To further emphasize the difference, might I suggest that should a committee or association offer a contract to the effect, that should a member have been obliged to pay hospital and/or doctors' bills, they would undertake to reimburse him in whole or in part, that would, I think, be a contract or indemnity."

Superintendent of Insurance for Ontario (Mr. R. Leighton Foster, K.C.).

"I doubt very much if your plan constitutes 'insurance' within the meaning of the Ontario Insurance Act. However, the plan is new to me and I am reluctant to give an *ex parte* opinion. You may assume that if my view changes I will communicate immediately with you." (No further reply received).

Superintendent of Insurance for Quebec (Mr. B. Arthur Dugal).

"So far, I am of the opinion that the plan of hospitalization which you have described in previous correspondence is not the kind of insurance which would come under the Insurance Act of the Province of Quebec."

In later correspondence, Mr. J. A. Paradis, the Assistant Superintendent of Insurance writes:

"I am of the opinion that the plan submitted might be considered as the object of a mutual benefit association, as covered by subsection I of section 65 of the Quebec Insurance Act, which reads as follows:

> 'The words "mutual benefit association" mean any association established with a view by means of contributions from its members, of making provision for those of its members who are afflicted by sickness, accidents or reverses of fortune, or subject however to section 217, in the case of the death of their children or wards, and, in case of the death of members, for their widows and orphans or legal representatives.'

"The plan submitted provides for hospital services to the subscribers afflicted by sickness or accident, and such subscribers should be considered as members of a mutual benefit association.

"Section 109 of our Act requires the registration of such an organization, after the fulfillment of the formalities required by the law.

"For your information, I might add that the foregoing opinion is now supported by our Law Department."

He states also that Article 2468 of the Civil Code, which applies to a contract by which the insurer undertakes to indemnify the insured against loss or liability from certain risks or perils, does not apply to the type of group hospitalization described in our enquiry, such being the usual form developed on this continent.

Acting Superintendent of Insurance for New Brunswick (Mr. R. P. Hartley).

"I do not think that this service comes under the classification of insurance."

Superintendent of Insurance for Prince Edward Island (Mr. H. R. Stewart).

"I wish to assure you that insofar as the Province of Prince Edward Island is concerned group hospitalization plans will not be considered as insurance or coming within the provisions of the Insurance Act."

Acting Deputy Provincial Secretary for Nova Scotia (Mr. Chas. Lamb). (Matters relevant to insurance come under the Department of the Provincial Secretary).

"As the scheme in its essence is a contract covering a period only of one year and is service rendered in return for a stipulated consideration, this plan does not seem to come within the category of Insurance but more in the category of simple contract.

"In view of the fact that the Province of Nova Scotia is guided in Insurance by the decision of the Dominion Department of Insurance at Ottawa, I can do no better than to affirm the statement of G. D. Finlayson, Esq., Superintendent of Insurance, contained in your letter of the 21st of September."

It has been emphasized by insurance company executives who have been consulted on this subject that where the hospitals assume the direct responsibility for service to subscribers, the agreements take the nature of service contracts rather than of insurance and that it is important that group hospitalization agreements be *distinguished from* rather than *identified with* insurance from the legal point of view.

While some insurance companies on this continent have inserted hospitalization contracts in their policies, there would seem to be little tendency at the present time for the companies to develop these plans as business ventures. At the same time insurance officers have been

exceedingly kind in assisting these various group plans with advice and actuarial data.

RELATIONSHIP TO NATIONAL HEALTH INSURANCE

It has been suggested that, should national or provincial health insurance be adopted in the near future, such development, *ipso facto*, would bring about the discontinuance of any group-hospitalization plan then in operation. Whether this would be so or not would depend upon (*a*) the type of health insurance adopted, and (*b*) the form of group hospitalization provided. If a general plan of compulsory health insurance be developed along those lines which now seem most favoured by many of the groups or parties concerned, insurance would be compulsory for certain lower wage groups only and there would still be ample room for a voluntary plan to provide hospitalization for those not covered by the compulsory plan of health insurance. However, those group-hospitalization plans in industrial communities which cater particularly to the employees of large industries and which provide public ward accommodation only might be materially affected.

It is of considerable significance that provision has been made for group hospitalization in the 1935 Health Insurance Act for British Columbia.

SECTION FIVE

STATEMENT OF COMMITTEE RESPECTING THE PRINCIPLE OF GROUP HOSPITALIZATION

This Committee is agreed that the chief obstacle preventing the general public from taking greater advantage of the facilities offered by the excellent hospital system prevailing in Canada is a financial one. Were this removed or minimized the high esteem in which our hospitals are held by both the medical profession and the public would result in more frequent and earlier hospitalization than prevails at present, thus bringing to the patient earlier and better diagnosis and treatment than can be effected in many cases without the assistance of hospital facilities.

The Committee is convinced also that, even with the praiseworthy assistance of provincial subsidies to public hospitals for public ward (and in some provinces all) patients, hospital charges are now kept as low as is consistent with the necessity of endeavouring to some extent to balance the annual budget, a task for which many hospitals find their revenue quite insufficient. Administrative economies would seem to have been carried, on the whole, as far as is compatible with efficient operation. Therefore, if our hospital facilities are to be more widely utilized by the public it would seem logical that this might be most effectively realized by such modification in the financial relations between the hospitals and the public whereby the financial reimbursement which hospitals must receive for services rendered will not prove a hardship to the individual nor a barrier to prevent patients taking full advantage of the hospital facilities.

Group hospitalization has been devised as a means of reducing this burden of hospital costs to the patient or family and at the same time of assuring to the hospital a steady and essential source of revenue. Fortunately there has been sufficient widespread experience to give this committee some idea of results obtained in actual operations. *It is the opinion of this Committee that the principle of group hospitalization, or the periodic payment plan for hospital care, is fundamentally sound; if such plans are carefully safeguarded from certain undesirable features that might be introduced and are operated in accordance with the recommendations discussed later in this report, the advantages to be anticipated by all parties involved should definitely outweigh the possible disadvantages.*

Group hospitalization by itself cannot be considered as a panacea for the problem of meeting the cost of sickness; it is but a partial solution, for the remuneration of the physician, the nurse (hospital "special", home or visiting), the dentist, and the druggist still offer difficulties of major import to the patient. But the patient is in a much better financial state to meet these other costs if his immediate hospital bill has been minimized or eliminated entirely. The substitution of an average for an individual risk can be achieved by periodic payments which, computed on a daily basis, can be likened to the cost of a three-cent postage stamp, a newspaper, or a couple of cigarettes, depending upon the type of hospital insurance developed. There are certain features of group hospitalization which this Committee would like to see developed more as the present early experience leads to greater clarification of the *modus operandi*; there are other details encountered in some plans which might well be superseded by better arrangements; these factors are considered in Section VI.

SECTION SIX

RECOMMENDATIONS

A.—GENERAL RECOMMENDATIONS

1. Some form of voluntary group hospitalization, either as an entity or as part of a broader voluntary plan, should be included in any national or provincial plan of health insurance obligatory to low income groups; such group hospitalization should be available to those above the specified income level.

2. Before acceptance or promulgation of any group hospitalization plan, such should have received the approval of the local medical society and the local hospital council or provincial hospital association. Any suggestions from these bodies should be given careful and sympathetic consideration.

3. No plan should be set in operation without a clear understanding with the provincial and federal superintendents of insurance with respect to its status under insurance legislation and regulations. It would seem most advisable also that the Hospital Department in the provincial government be closely consulted during the formative stages.

4. If at all possible all public hospitals in the community should be included in the plan. Such arrangement, by permitting free choice of hospital, may often prove of distinct advantage to the subscriber; it is fair to all of the hospitals; it prevents friction between the local hospitals with the inevitable consequent loss of prestige before the public; it would most appeal to the medical profession and would permit a fine type of group publicity through the press and other channels. Joint participation emphasizes the public service aspect of the proposal rather than creates the impression, as when a single hospital organizes alone, of a money-making plan primarily organized to benefit that hospital. At the same time, if the other public hospitals in a community do not desire to participate after invitation, such decision should not deter the one hospital from announcing its plan to the public.

5. To facilitate cooperation between local or nearby hospitals, a local Hospital Council should be formed, such to include representatives of all local public hospitals or of hospitals in closely adjacent towns in a thickly populated semi-rural area.

6. The ideal arrangement would be to include in a plan hospitals extending over a large area, perhaps an entire province or more. Until such development can occur, it would be in the best interests of the subscribers if emergency hospitalization, certified as such, elsewhere in Canada or even in the United States, could be remunerated on the basis of the charge or cash equivalent of the accommodation provided for in the contract.

7. Inasmuch as some contracts examined have not been as carefully worded as would be desired, for instance, in defining what diseases or physical conditions are or are not included, a careful checking of existing or proposed contracts by a committee composed in part of representatives of the medical staff(s) concerned is strongly recommended.

8. No plan should be placed before the public unless its by-laws or regulations provide for benefits that are

fair to both subscribers and hospitals; unless the control of the plan rests with the participating hospitals and subscribers rather than with an intermediate body; unless the overhead expenses of administration be at a minimum consistent with efficiency; unless the rates to subscribers be kept as low as will be fair to the hospitals, will meet administrative costs and will set up a reasonable reserve for epidemics and other unusual demands. "No individual or group of persons should be allowed to enjoy any profit or financial gain from the group hospitalization plan other than reasonable compensation for services actually rendered." (Rorem).

9. If experience proves that the rates set are unnecessarily high, such situation should be met by lowering the annual charges or by increasing and broadening the benefits. In this decision the hospitals might well be guided by the desires of the subscribers.

10. Rates should be kept as low as is consistent with adequate service. At the same time every plan should give full payment for service rendered. Charity should not be expected in this type of hospitalization. If the regular rate, *e.g.*, for the public ward, be below the actual cost of care, as is the case in most large city hospitals, the hospital should receive the *actual cost* of caring for such patients. Perhaps in some provinces, where the government grant applies to all patients rather than only to those for whom is paid not more than the recognized public ward rate, the actual cost might be considered as the cost of that particular service less the government grant.

11. Before final drafting of the clauses governing the operation of any group hospitalization plan, competent legal advice should be sought.

12. Dependents of subscribers should be included. From a financial viewpoint dependents add an uncertain factor to the risk, and rates for dependents may require higher revision. Also *all* dependents should be listed in the contract. Some plans prevent undue hospitalization of dependents by charging, for such, a nominal daily rate. Obstetrics should be covered also. If not enrolled in the group plan, under special rates for dependents, they should at least be given substantial discounts by the participating hospitals.

13. Payment. A single hospital operating a plan may receive the funds directly or through group representatives. Where a number of hospitals participate, a fund manager and committee are usually appointed and the hospitals paid an agreed sum from this common fund. Until reserves are being set up, it is frequently advisable to hold back a portion of the payments until the end of the year when, if necessary, these residual claims can be pro rated.

14. While many plans have successfully enrolled individuals, the risk is less and the overhead cost reduced when subscribers are accepted in groups only. Subscribers who enroll as quite large groups, thus reducing the required bookkeeping, or who represent a stipulated high percentage of the employees of a firm or concern, thus reducing the morbidity risk for the hospital(s), may be given a reasonable discount from the regular rates.

15. The frequent basis of public ward hospital benefits, even with deductions or discounts for higher priced accommodation, may limit the appeal of the plan to many potential subscribers. For this reason it would seem advisable that future plans be arranged either (*a*) on a basis of semi-private accommodation with proportionate credit allowance for private rooms or (*b*) with a choice of, say, two rates giving a choice of either public or private service, those choosing and paying for the public ward plan having the privilege of taking higher priced accommodation if desired and upon payment of the difference.

16. In view of other provisions available in most communities and other factors, it would seem advisable to exclude from the fund hospitalization for certain conditions. These should be clearly and explicitly indicated and should include:—

(*a*) patients who have been certified for care in a hospital for mental diseases or who are obviously suffering from a mental disorder for which general hospitals participating are not equipped to give treatment;
(*b*) communicable diseases for which the participating hospitals are not prepared to give care;
(*c*) non-surgical pulmonary tuberculosis and
(*d*) acute venereal disease.

Non-surgical pulmonary tuberculosis may be admitted for, say, 10 days, to permit verification of diagnosis and the making of arrangements for care elsewhere.

17. A time limit for hospitalization in any one year (specify calendar or enrolment) should be defined. Three to four weeks would cover the demands of the vast majority of the subscribers and would permit lower rates than otherwise. Hospitalization beyond the specified period should be provided at a discount.

18. Hospitals should clearly set forth in the contract that every effort will be made to provide hospitalization in their own or in another institution and that, failing such arrangement, a return of the premium paid for that particular year (or period to be specified) will be made.

19. A reasonable waiting period after enrolment is but fair to both the hospitals and the other subscribers. This varies in practice, but would average about four to six weeks. It should be clearly set forth in the basis of contract whether or not hospitalization for pathological conditions existing at the time of enrolment will be permitted. This would include such conditions as hernia, chronically enlarged tonsils, etc. The waiting period for obstetrical cases should be ten months. There should be no waiting period for accidents.

20. Except in case of emergency, no subscriber or dependent should be admitted to a participating hospital without a written or telephoned request for such admission from the doctor in charge.

21. As many "extras" and special diagnostic or therapeutic facilities or services as possible should be included. For those not included a special discount may be given. (See No. 33).

22. Clear and full statements concerning various details of the plan and answering probable questions should be furnished regularly to the subscribers, to the medical profession and to the public.

23. If a subscriber becomes unemployed he should be permitted to remain eligible as long as he continues to pay his dues promptly. It should be kept in mind, however, that there would appear to be a higher incidence of hospitalization and a longer period of hospitalization among the unemployed.

24. When plans are promoted by private lay groups either for personal profit or on behalf of potential subscribers hospitals should refuse to bid for the contract, exclusive or otherwise, by offering "bargain rates" below cost or below the accepted rate for the selected accommodation. It is unfair to non-subscriber patients and to those private or public individuals or bodies eventually responsible for the hospital's finances. (See No. 10).

25. If large groups of employees in the community are already covered by satisfactory insurance plans but their dependents are not covered by such insurance, a proposed group hospitalization plan might cooperate with such existing plans so as to provide protection for dependents only at a special rate to be agreed upon. (Edmonton plan).

26. Where two or more hospitals participate in a group plan, the contract should definitely state that in case of legal action with respect to treatment entered into by or on behalf of a subscriber or dependent, such action shall not involve other than the hospital where the treatment was given.

B.—Recommendations Respecting Details Relating to the Medical Profession

27. During these early years when the various details of organization, of rates, etc., are in the formative

stage, it would seem advisable to leave the *medical* aspect of hospital care entirely out of the picture. This would be not only advisable but should be insisted upon where no remuneration to the medical staff for its services is planned. (See also No. 29).

28. There should be free choice of doctor (as of hospital) by the patient. This may be limited to some extent by the staff arrangements in some of the participating hospitals, but such hospitals should accept patients under the plan only under such conditions and in such type of accommodation that will permit, as fully as is consistent with efficient professional care, free choice of doctor. Teaching hospitals and other institutions desiring to participate in group hospitalization plans and at the same time preserve a "closed" staff, could either accept subscriber-patients for the private and semi-private wards only, which are usually "open", or could set aside special accommodation of a semi-public nature, should the latter type of service be an essential feature of the plan. (See also 35*b*). Whatever limitations are necessary, should be clearly set forth in literature issued to the subscribers and to the profession.

29. In view of the increasing tendency, particularly in large hospitals, to prohibit medical charges to paying patients on the public wards, hospitals with such an arrangement, or contemplating such, should not present to the public any plan offering public ward service to subscribers. No arrangement should be made which would deny the medical attendant the right to fair remuneration for his services. If such a hospital be participating in a joint plan offering public ward accommodation, special reservations or provisos applying to such hospital and acceptable to its medical staff might be made. (Some hospitals permit a doctor to charge subscribers on the public ward but not other patients. Possible complications can be foreseen.)

30. When a teaching hospital associated with a medical college is considering participation in a group hospitalization plan, consultations should be held with the heads of teaching departments with respect to the effect of any such plan upon the teaching facilities in that hospital. If it be essential that the teaching staff retain the direction of the public ward care in that hospital it is recommended that the plan adopted be such as will permit this arrangement to continue.

31. Apparent undue hospitalization or unnecessary prolongation of such might best be handled by referring such cases to a committee of the medical staff of the hospital concerned or of the staffs of the combined hospitals, which committee would make its decision or submit its advice to the executive body of the fund after consultation with the doctor in charge of the case.

32. Inclusion of out-patient care (where such facilities exist) as part of the group hospitalization benefits, as is sometimes suggested or expected by subscribers, is not fair either to the doctors donating their services to the out-patient clinic or to the subscriber's family physician. Such privileges should not be included.

However, when subscribers or dependents patronize the hospital radiological, pathological, physiotherapeutic or other diagnostic or therapeutic services other than as in-patients, it would stimulate such patronage and would be in the interests of both the subscribers and the hospital if such facilities could be available at a small discount from the usual rates.

33. Where radiological and pathological services are included, the basis of remuneration of the radiologist or the pathologist may be such that he would be seriously affected by the lost departmental revenue. In such instances the director of the affected department(s) should be remunerated from the fund or by the hospital on a basis mutually satisfactory. This situation might affect also the anæsthetic staff, the physiotherapist, the pharmacist and others.

34. It would be advisable if participating hospitals instructed their resident staff and personnel to refrain from recommending certain doctors to enquiring subscribers. In at least one Canadian plan each subscriber indicates on his application form the doctor of his choice.

35. If the principle of group hospitalization proves sound and acceptable in the light of experience, it would be logical to expect a desire for an extension of these plans to include medical service. Should such development occur it would seem most essential that such plans should provide for:

(*a*) Free choice of doctor by the patient. Unless this is provided for strong objection by doctors discriminated against and by the local or other medical associations may be anticipated. From the viewpoint of dollars and cents, it might appear economical to appoint a doctor or doctors on salary after a competitive and bargaining selection, but the resultant dissatisfaction both within and without the fund would render this saving (and such is extremely doubtful) of negative value.

(*b*) Such arrangement for the extension of hospital facilities to non-staff medical men which will permit them to give that treatment to member-patients for which they are qualified and which will at the same time, permit the hospital staff to exercise that supervisory power deemed essential on behalf of the patient and the hospital. Inclusion of the doctors' fees in the plan benefits would emphasize the importance of a working agreement with a full understanding concerning those participating hospitals with a limited staff.

(*c*) Matters relating to the services rendered by the medical profession should be referred to a medical committee appointed by the doctors participating or eligible to participate in the plan. No decisions affecting the medical participants should be made by the governing body of the plan without their consent.

(*d*) Payment of the doctor would have to be of necessity on the basis of service rendered; a per capitation or salaried arrangement would necessarily interfere with the free choice of physician and cannot be recommended by this Committee for this type of service. Any schedule of fees should be in keeping with those fees recognized by the provincial medical association and should be acceptable to the local medical society.

For the collection of much of the data embodied in this report, this Committee is indebted to the Department of Hospital Service of the Canadian Medical Association, and to the Council on Community Relations and Medical Practice of the American Hospital Association, of which body Mr. C. Rufus Rorem, Ph.D., C.P.A., is consultant in Group Hospitalization. It wishes also to thank those many officers of group funds and of hospitals who have made their local experience available to this Committee.

All of which is respectfully submitted,

HARVEY AGNEW, *Secretary.* FRED. W. ROUTLEY, *Chairman.*

It was duly moved, seconded and agreed that this report be received, that it be published in the Supplement of the *Journal* for the information of all interested, and that the Committee be continued and asked to present an additional report to the next annual meeting of the Association.

ELECTIONS

The following were elected to office:—

President—Dr. J. C. Meakins, Montreal.
President-elect—Dr. Hermann M. Robertson, Victoria.
Honorary-Treasurer—Dr. F. S. Patch, Montreal.
Chairman of Council—Dr. Geo. S. Young, Toronto
General Secretary—Dr. T. C. Routley, Toronto.

Members-elect of the Executive Committee—Drs. J. E. Bloomer, Moose Jaw; Duncan Graham, Toronto; J. G. FitzGerald, Toronto; A. Primrose, Toronto; A. T. Bazin, Montreal; Léon Gérin-Lajoie, Montreal; K. A. MacKenzie, Halifax; J. S. McEachern, Calgary; E. S. Moorhead, Winnipeg; A. S. Kirkland, Saint John.

The following appointments were made by the Executive Committee to the Editorial Staff:—

Editor—Dr. A. G. Nicholls, Montreal.
Assistant Editor—Dr. H. E. MacDermot, Montreal.
Managing Editor—Dr. F. S. Patch, Montreal.

Chairmen of Committees

The Executive Committee appointed the following Chairmen of Committees:

Personal Archives—Dr. C. F. Wylde, Montreal.
Legislation—Dr. G. D. Stanley, Ottawa and Calgary.
Advisory Committee on Hospitals—Dr. S. R. D. Hewitt, Saint John.
Constitution and By-Laws—Dr. Geo. S. Young, Toronto.
Credentials and Ethics—Dr. D. A. Stewart, Ninette.
Economics—Dr. J. D. Adamson, Winnipeg.
Group Hospitalization—Dr. F. W. Routley, Toronto.
Maternal Welfare—Dr. John McQueen, Winnipeg.
Medical Education—Dr. H. G. Grant, Halifax.
Meyers Memorial—Dr. J. T. Fotheringham, Toronto.
Orations, Scholarships and Awards—Dr. J. C. Meakins, Montreal.
Osler Memorial—Dr. Campbell Howard, Montreal.
Pharmacy—Dr. V. E. Henderson, Toronto.
Program—Dr. Duncan Graham, Toronto.
Public Health and Medical Publicity—Dr. J. G. FitzGerald, Toronto.
Study Committee on Nursing of the Canadian Medical Association and Canadian Nurses' Association (Medical Representatives)—Drs. G. Stewart Cameron, Peterborough (*Chairman*); J. C. Meakins, Montreal; Duncan Graham, Toronto; G. H. Agnew, Toronto.
Hospital Internships—Dr. J. J. Ower, Edmonton.
Conference on Medical Services in Canada—Dr. W. J. P. MacMillan, Charlottetown.
Study Committee on Cancer—Dr. A. Primrose, Toronto.
C.M.A. Representative on Canadian Hospital Council—Dr. A. K. Haywood, Vancouver.

Committee on Membership

It was duly moved, seconded and agreed:—

"That, under Section 13 of the revised By-Laws, a special committee be set up to be known as the Membership Committee. This Committee shall inquire into reasons why a larger percentage of the practising physicians of Canada are not shown in the present membership. This might include an investigation of the individual resignations over the past five years; an inquiry into the number of new members joining the Association during the past five years as related to the number of graduates of Canadian Universities or to the number of doctors beginning practice in Canada during the past five years; an inquiry into the total annual costs to the individual doctor if he is a member of the national and local Associations; to arrange, if possible, a composite fee to cover both local and national fees; and, in order to make the preceding clause as attractive as possible, to inquire whether arrangements could be made by the national Association with its central machinery towards assuming part of the local administration work, and thereby cutting down local costs and reducing the local fee."

It was duly moved, seconded and agreed that Dr. F. S. Patch be appointed Chairman of the Committee on Membership, with power to add.

Golf Committee

Consideration was given to the advisability of forming a Golf Committee in the Association, whose duty it would be to look after all arrangements pertaining to the Golf Tournament and individual golf at annual meetings. It was agreed that a suitable note should be published in the *Journal*, requesting all members who would be interested in forming a Golf Committee to submit their names to the General Secretary, and, if sufficient interest is displayed, that action be taken by the Executive Committee at its next meeting.

Committees in Provincial Associations

It was the opinion of the Executive Committee that there should be some coordination between C.M.A. Committees and similar Committees in the Provincial Associations, and it was duly moved, seconded, and agreed,—

"That the General Secretary advise each of the Provincial Associations as to the Committees appointed by the C.M.A., and request that the Chairman of the analogous committee in the Provincial Association be a member of the C.M.A. Committee, and that if they have not analogous committees to those appointed by the C.M.A., they be urged to appoint them."

Honorary Membership

Honorary Membership in the Association was conferred upon Dr. Allan Roy Dafoe, of Callander, Ontario.

Life Membership

Life Membership in the Association was granted to Dr. D. F. Gurd, of Montreal, and to Dr. A. Primrose, of Toronto.

Next Meeting of the Association

It was decided that the next annual meeting will be held in Victoria, B.C., on June 22, 23, 24, 25 and 26, 1936.

Message from the Prince of Wales

The General Secretary was instructed to send greetings from the Association to His Royal Highness, the Prince of Wales, on his birthday. This was done on June 22nd and the following message was received in return:—

"Prince of Wales sends grateful thanks to members Canadian Medical Association for their good wishes."

Conclusion

Attention was given to many other details in connection with the work of the Association, which were passed to the various committees for consideration and report.

All of which, on behalf of the Council and the Executive Committee of the Canadian Medical Association, is respectfully submitted.

T. C. ROUTLEY, *General Secretary.*